Health Care Financing Administration

Forum

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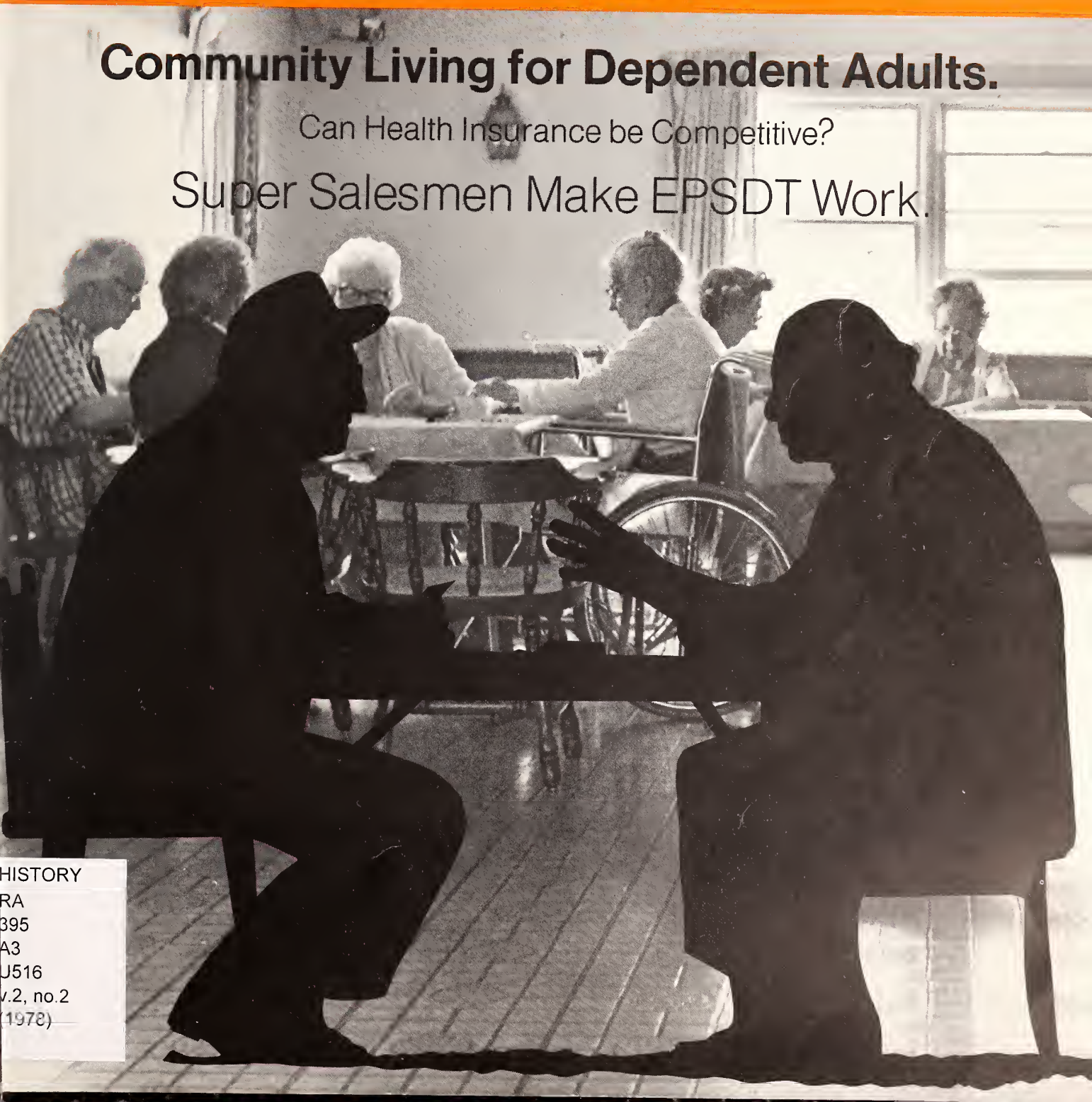

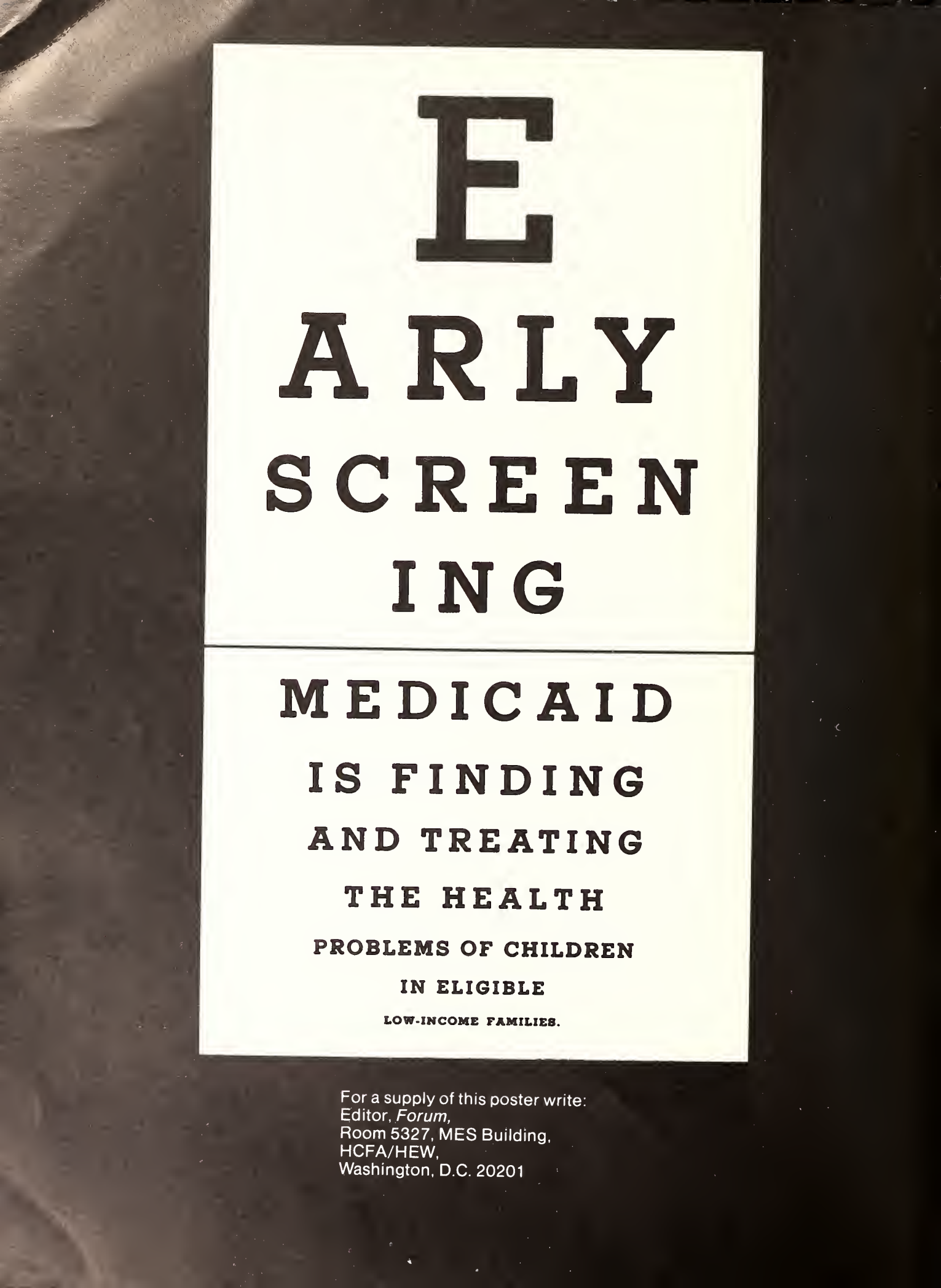

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Articles

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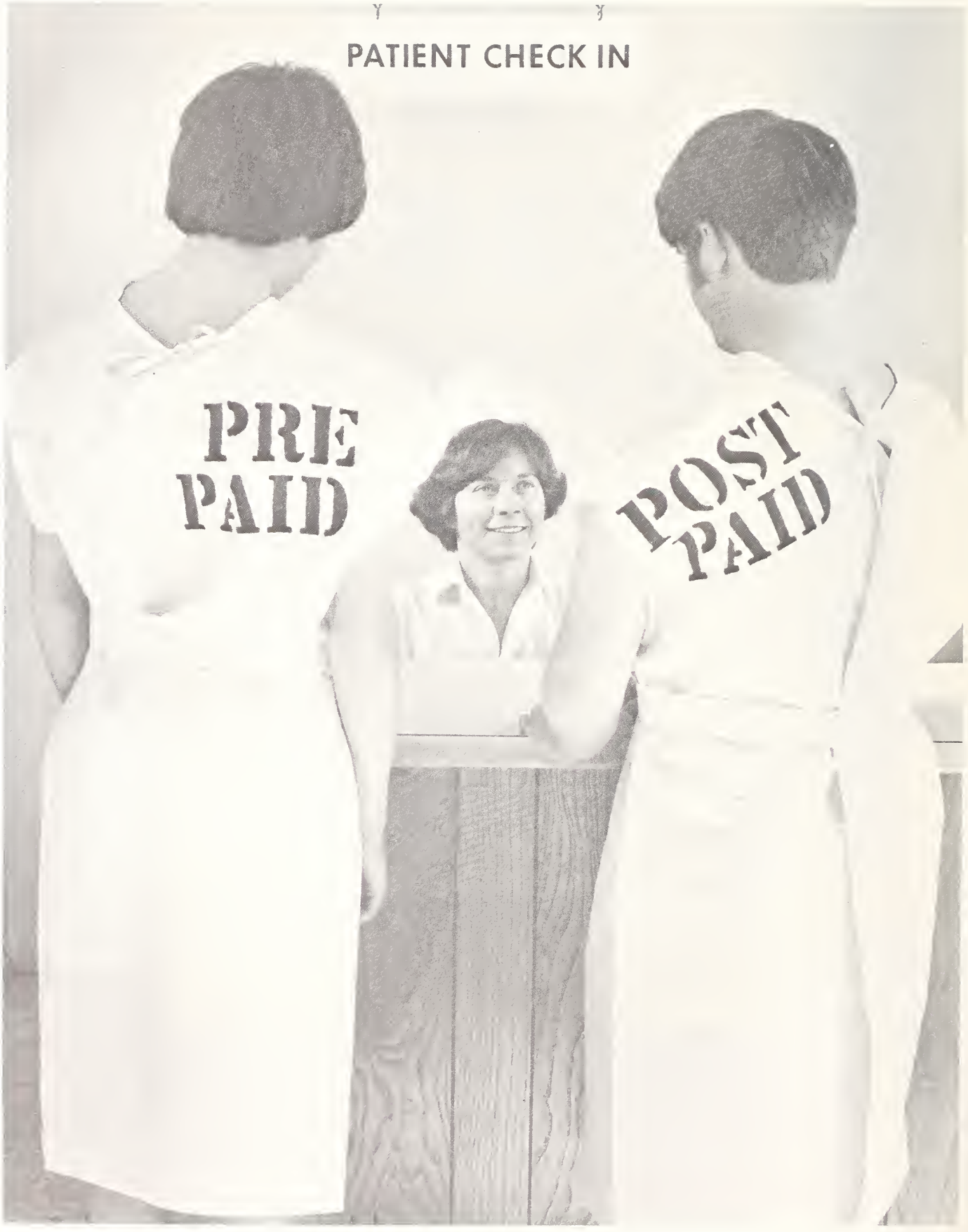
PATIENT CHECK IN



Physicians Combine Fee-for-Service with HMO Practice.

by Milton Golin

Who says fee-for-service physicians must gird for combat against prepayment plan doctors? Today, more than 400 Illinois and Indiana practitioners are treating prepaying and postpaying patients side by side in scores of offices and hospitals, handling the prepayment share of their practices through a Chicago-based central office.

Many of these physicians hope they can show colleagues and Government alike that here is a way to bring prepayment honorably into the mainstream of American medicine, rather than treat it like a stepchild.

The time seems right for broader trials of combined fee-for-service/prepayment programs. Not so, though, a decade ago, when health insurance carriers, notably Blue Cross and Blue Shield, either studiously ignored or vigorously opposed proposals for outpatient coverage—and when the only big success in prepayment, Kaiser Permanente, was still smarting from years of blistering attack for its unorthodox style of financing medical service.

"Even before our dual operation got off the ground six years ago, the prepayment purists were sneering," recalls Mervin Shalowitz, M.D., an internist who is executive director of Intergroup. "Some Kaiser and group health people accused us of bastardizing the prepayment movement by combining it with fee for service. Besides, they insisted, it could not work because physicians simply would not function both ways."

Despite the gloomy prognostications, the Intergroup doctors are doing just that—and in the process improving professionally, educationally, and economically, at a time when many of the federally defined prepayment-only programs known as health maintenance organizations are running into considerable trouble.

To be sure, not all HMOs are under a cloud. In some areas, particularly California, where a number of newer HMOs have been forced to shut down, there are totally prepayment HMOs in operation that give service of high quality, maintain economic soundness and satisfy patients. Besides Kaiser, with its more than three million members and 3,000 physicians, these include the pioneering Ross Loos Clinic in Los Angeles and the Group Health Cooperative of Puget Sound in Seattle.

These HMOs won good reputations as prepayment groups before Federal health planners passed the HMO Act in 1973. Now, at least six million people are enrolled in 180 prepayment medical groups around the country. Of these, only about 40 groups are qualified as HMOs. Contrast that with 9,500 fee-for-service medical groups and their nearly 80,000 physicians who have some 600 million patient encounters annually.

It is those 9,500 privately financed groups that Dr. Shalowitz views as the reservoir for the prepayment/postpayment medical service arrangement set up in Intergroup's 25 multispecialty groups. A major step in that direction was taken last October, when the 432-clinic American Group Practice Association adopted the policy that every member "be involved in a prepayment mechanism as part of their practice." Some AGPA members, such as Wisconsin's Marshfield Clinic, already operate that way.

Intergroup is a good example of how the system can work. Employees of the 50 firms participating in the Intergroup program—Sears and Illinois Bell are among them, as well as insurance carriers like CNA Insurance—decide on one of the 25 participating medical groups as a provider of prepaid care. The employer pays all or part of the premium, which averages $35 a month for an individual and $110 for a family unit. Premiums have risen 40 percent since 1972, reflecting inflation chiefly, but also expanded benefits.

Copayment for an office visit is three dollars, for an after-hours visit or house call $10 and for maternity care $100. For prescribed drugs the patient pays $50 yearly, plus 20 percent of the remaining costs. There are no additional charges for hospitalization or specialist's services.

Milton Golin produces a monthly newspaper for fee-for-service and prepayment group physicians and is a veteran writer in the health field. The article first appeared in the AMA News *(Dec. 1977), a publication of the American Medical Association.*

The individual physician has little need to change his routine because of the tie-in with Intergoup. He sees prepayers under the same appointment arrangement as other patients, and his fee from each prepayer is disbursed to him (through his clinic) as a monthly capitation, no matter how many office, hospital, home, or emergency calls are involved, or even if there are none.

Operations and financing

As for the medical groups, each must meet stringent standards of quality assurance, peer review, key specialty representation, grievance procedure, lab and x-ray availability, ancillary services, home nursing care affiliation, patient records, professional administration and medical direction. "We turn down more applying groups than we take in," says Dr. Shalowitz. Before acceptance, he and staff experts conduct several site inspections to confirm adherence to standards, and similar visits are made periodically thereafter.

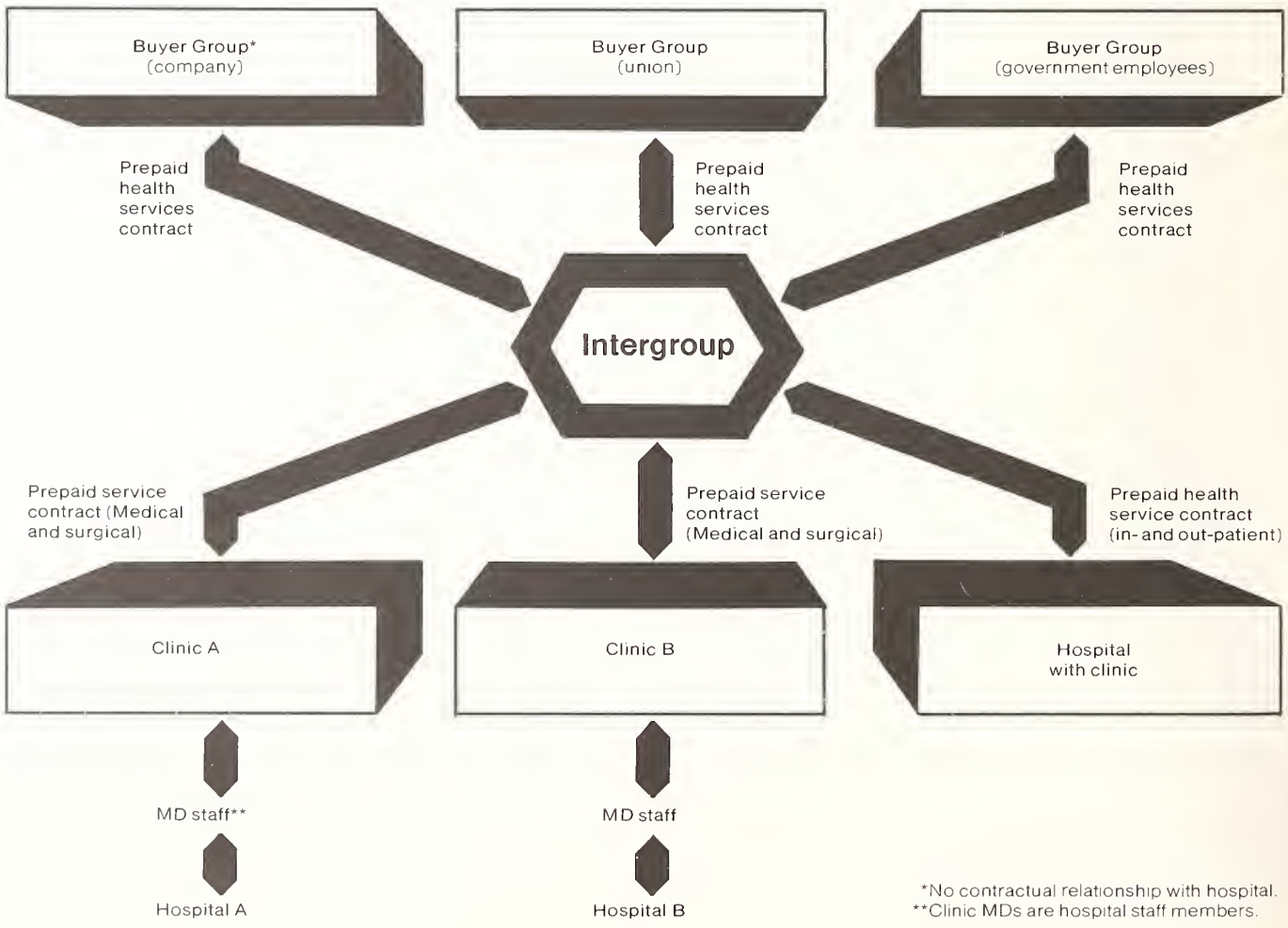
Every provider clinic receives monthly computer printouts which show incurred dollar costs, hospital admissions and bed-days, and frequency and type of ambulatory care visits. On the basis of actuarial utilization estimates, Intergroup sets aside part of the prepayment premium for hospital expense; 95 percent of whatever remains of this fund at the end of the year is returned to the medical group. Most of the 25 groups receive such a return, in a few instances amounting to $30,000 or more.

"It is not a bonus, not a payoff, not a monetary inducement to shorten hospitalization," emphasizes Dr. Shalowitz. "It is a dividend from a shared-risk fund. We probably give back more money than any HMO in the country."

Dr. Shalowitz considers the term "health maintenance organization" a misnomer: "I especially dislike the second word because you cannot 'maintain' anything over which you have no control." Nevertheless, after more than five years of operation, Intergroup did, in April 1977, become federally qualified as an HMO.

The designation was sought in order to facilitate marketing of the plan with companies of 25 or more employes which are legally bound to offer workers an HMO as one of several health insurance options. But, unlike virtually all other HMOs, Intergroup never has accepted any Gov-

How Intergroup relates with buyers and providers



*No contractual relationship with hospital.
**Clinic MDs are hospital staff members.

ernment funding.

"We don't plan to," insists Dr. Shalowitz, "since we have a positive cash flow and are in the final stage of repaying $250,000 that CNA lent us. From the start, we've had the goal of putting together a viable program without Federal money or intervention."

That was his objective 20 years ago, when he organized the North Suburban Clinic, now a 25-physician group in Skokie, Ill., and the nucleus of Intergroup. Prepayment as a respectable method for medical service was before its time then, and so was systematized quality assurance.

Dr. Shalowitz was ahead of his time also in obtaining commercial laboratory licensing for the clinic and in instituting a system of strict chart and peer review. The laboratory licensing is not required by Illinois law, but Dr. Shalowitz sought it "because it forced us into a review process by the state health department."

When Dr. Shalowitz and his colleagues sought insurance coverage for ambulatory care conducted with such quality assessment, they met turndown after turndown, despite his contention that this kind of group practice is ideally set up for audit.

"Now, of course, a lot of insurance companies and Blue Plans do write policies which have ambulatory care features, but usually with big front-end deductible and copayment because what the doctor does in his office is so variable—it ranges from the ridiculous to the superb.

"In those early years, the idea of prepayment was unclear in our planning. What we had in mind was developing some kind of pluralistic approach, both from a funding and a conceptual standpoint, that would guarantee quality to any third-party payer for the dollar spent on ambulatory care. As it turned out, our system became essentially the first anywhere with both prepayment and fee for service. It evolved off the top of our collective heads and was not a copy of anything."

Consumer saving

Year after year since then, Intergroup has chalked up impressive gains for its cost-conscious holder groups and employe subscribers—most remarkably in reducing hospital admissions and stays (30 to 60 percent less than for fee-for-service patients generally in the United States).

A big reason is that these patients no longer need to sign in at a hospital for diagnostic work-ups or emergency care which can be managed efficiently at the medical group. Too often in other situations, hospital entry is the only way to qualify for insurance coverage.

The most important characteristic distinguishing Intergroup from all-prepayment HMOs is its ability to provide comprehensive care with none of the capital costs borne by most HMOs in the form of land, buildings, and equipment. Should this concept become widespread it might save Americans millions, even billions of dollars.

"All our medical groups are in place, have been for years," Dr. Shalowitz never tires of emphasizing. "Also, we serve urban, suburban, and rural populations. The system seems adaptable to many areas of the country.

"From the professional standpoint, it offers a practitioner his first opportunity to call the cost signals again in the entire health system—the hospital dollar, the ambulatory service dollar, every cent the patient or his employer spends. Where else can this occur? The strictly fee-for-service physician doesn't really control that dollar; he only sees it spent, without optimum health benefit. And also, for the first time, our kind of practitioner can demonstrate accountability to the government and the public."

Fine words, one might respond, but don't they suggest that no such plan can succeed unless every physician practices in a tightly disciplined multispecialty clinic? What is the competent practitioner to do if, for one valid reason or another, he prefers the solo route? How might he fit into the Intergroup style of picture? For at least some of these soloists, Dr. Shalowitz sees a way:

"Suppose a dozen or more physicians who practice individually in a medical office building agree to organize an independent practice association form of HMO by using a common lab, x-ray facility, record system and administrator. In fact, each of Intergroup's member clinics is an individual practice association for Federal qualification purposes.

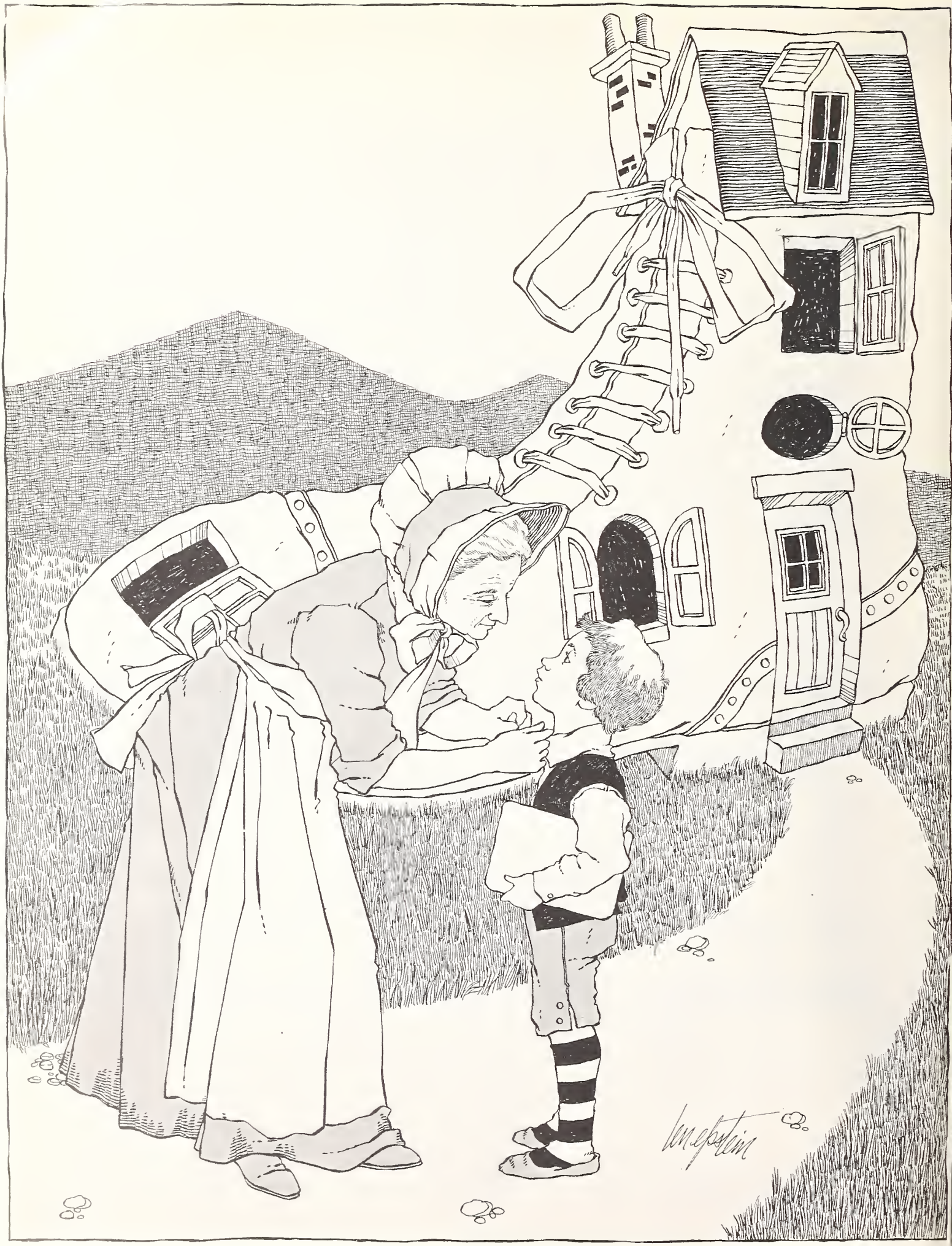
"If those IPA solo doctors were also then to include suitable types of surgical and medical specialists for cross referral, and incorporate a method to track patients for quality care review, the unit might well be embraced by Intergroup or by a comparable organization which has provision for both prepayment and fee for service."

Whether or not such a trend develops, Intergroup's growth seems assured. When the architect of HMOs, Paul M. Ellwood, Jr., M.D., surveyed the "group of groups" in 1976, he lavished praise on it while estimating that the organization could easily absorb 125,000 subscribers (more than four times the present membership) "without addition to present staffs or expansion of facilities."

The forecast fits with Government and industry projections that by 1980 at least one-fifth of the U.S. population, about 50 million people, will belong to an HMO or other prepaid comprehensive health care plan. When so many Americans are involved, pressures for cost containment are sure to exceed those now being exerted on and by Government.

"No, please don't say it that way; call it 'cost consideration'," Dr. Shalowitz pleads. "Cost containment is a misleading term. We as physicians should not be lured into using it, nor should we be concerned about costs in the sense of containment.

"Consider, instead, the physician who wants to practice high-quality medicine, and can do so, using the most effective therapeutic and diagnostic modalities—setting sensible levels of care, for example, by not hospitalizing unnecessarily, not prescribing irrationally, ordering generic drugs when quality and source are known, using home health care and ambulatory surgery facilities when appropriate. If he does all these things, so-called cost containment will follow naturally as an effect. It is cost consideration that characterizes our Intergroup dual system." ■


ben epstein

Sterilization

Late in 1977 a Federal court ruling that HEW has authority to set standards for sterilization paid for with Federal funds set the department's rule making machinery into motion. HEW Secretary Joseph A. Califano, Jr. convened the first of 14 public hearings on the subject on January 17 in Washington. The following are excerpts from the hearing.

SECRETARY CALIFANO: Let me briefly open this hearing today on our proposed sterilization regulation.

The Department of Health, Education, and Welfare pays for about 100,000 sterilization operations each year. On several occasions in the past few years we have received reports that Federal funds have paid for sterilization of individuals who have not been fully informed about the permanent consequences of that medical procedure or who have not freely consented to such operations.

I asked Peter Libassi, HEW's General Counsel, Dr. Julius Richmond, the Surgeon General, and Robert Derzon, the Administrator of the Health Care Financing Administration, to study our practices and procedures and recommend to me a set of regulations.

As a result of that work, we proposed new regulations to limit HEW funding of sterilizations to those which the patient has voluntarily requested with full understanding of the irreversible consequences of the action. In addition, the regulations propose for the first time to prohibit entirely the use of HEW funds to pay for hysterectomies where the sole purpose is sterilization.

Patients would be required to sign a consent form that spells out clearly and simply in the patient's primary language the nature of the operation and its consequences. Doctors who perform sterilizations would be required to certify in writing that they had given the patient full information about the risks and benefits of this operation and that the patient has been informed that no Federal funds or benefits may be withheld or withdrawn if the individual chooses not to be sterilized.

The waiting period between the signing of the consent form and the operation would be extended from 72 hours to at least 30 days. The proposed rules continue current HEW policy that no one under 21 is eligible for sterilization paid for with HEW funds.

Sterilization of persons over 21 who are in a penal or mental institution would be funded only if approved both by a special review committee and by a court.

The proposed rules seek comment on two alternative provisions for funding sterilizations of persons over 21 who are mentally incompetent under state law. Under one approach, which is the current practice, HEW would not fund any sterilizations for such persons. The alternative proposed would authorize Federal funding of some sterilizations of mental incompetents in states where they are legal.

Both a special review committee and a court would have to determine that the consent was knowing and voluntary before Federal funding would be available.

General Counsel Peter Libassi will chair this hearing. I thank you all for coming.

"The 30-day waiting period does not impose an undue burden on hospitals and physicians. New York State has adopted this procedure and there have been no serious problems to date."—Rep. Shirley Chisholm

REP. SHIRLEY CHISHOLM of New York: The documentation of sterilization abuses has come from a variety of sources. Lawsuits, the research of several health advocacy groups and the General Accounting Office have all added to the growing body of information about the ways in which sterilization is on the increase.

It is clear that minority group women are most vulnerable to both overt and implicit coercion. Welfare mothers have been sterilized after threats that they would otherwise lose the benefits that form their only means of support. Young women who have never had children have been sterilized without adequate protection to ensure that the sterilizations were necessary and desirable.

Fears of genocide have haunted black Americans for many years in the wake of a wide range of pernicious policies, from the eugenics laws that are still on the books in some of our states, to the continuing practice some follow requiring that a poor pregnant woman consent to sterilization as a condition of medical care for her current pregnancy.

I wish to restate at the outset that I very much approve of the direction and the strong initiatives which HEW has taken in proposing these regulations.

I am particularly pleased that the published regulations substantially lengthen the time period that must elapse between consent to sterilization and the operation itself. The 30-day waiting period does not impose an undue burden on hospitals and physicians. New York State has adopted this procedure and there have been no serious problems to date.

The new requirement that information about the nature and effects of sterilization be in the patient's primary language is also crucial.

I am also very pleased to note that the minimum age for federally-funded sterilizations will remain at 21 years.

I would like now to outline for you three specific ways in which I personally feel the regulations should be modified.

I have strong reservations about permitting, under certain circumstances, sterilization of the mentally incompetent or the incarcerated. These individuals are inherently vulnerable and lack adequate recourse to challenge administrative decisions.

I am concerned that the language of the proposed regulations is too vague to fully protect the individual who is to be sterilized. The latitude given to the states in selecting the method by which review committees are convened to rule on proposed sterilizations and the rules by which they operate give the states room for abuse. I recommend further that a tighter selection procedure for the review committee be required, especially the selection of the patient advocate.

I am also concerned that the regulations do not address adequately the issue of medical procedures which will have the effect of sterilization. This could become a severely-abused loophole in the regulations. For example, if a young woman is advised she needs to have her ovaries and uterus removed because of an ovarian cyst, she should be told clearly that this operation will render her permanently unable to bear children.

Medical necessity will often make it impossible for a physician to delay certain procedures while the patient ponders the issue of impending sterility. Therefore, I do not recommend that there be a mandatory waiting period.

I also see no reason why consent forms explaining the impact of sterilization should not apply equally to these procedures as they do to voluntary sterilization, and they should be in the patient's primary language.

DR. TOMMY EVANS, past president of the American College of Obstetricians and Gynecologists and chairman of the Department of Gynecology and Obstetrics at Wayne State University of Medicine: I represent some 20,000 physicians and some 17,000 members of the Nurses Association of the American College.

With all of the positive elements of the proposed regulations, there are some areas which cause real concern. One is the 30-day waiting period.

Although this sounds like a terribly logical thing, in some instances, however, the waiting period can pose serious risks and hardships, and added costs to the patient. The onset of labor is frequently unforeseeable as is the necessity for intervening with emergency abdominal surgery.

Think of the patient who has made a decision, a very thoughtful decision with her husband, to terminate their

"I strongly and sincerely believe we ought to strengthen all of our Medical Practice Boards in the states and get out the magnifying glass any time there is any question of abuse of sterilization operations or anything else for that matter."—Dr. Tommy Evans

"One of our concerns is that we treat publicly-financed patients differently than non-publicly-financed patients."—Robert Derzon

child-bearing career after the eighth child.

Let's say that she has premature rupture of the membranes and goes into labor and has an emergency cesarean section. She can not be sterilized then because of the mandatory waiting period. She must come back later, at a time when her newborn baby needs her attention, and undergo this procedure with added discomfort and added risk of a second anesthetic. If a mandatory period is deemed necessary, please incorporate some mechanism for waiving this requirement to prevent additional surgery.

Age 21 has been selected as the age of consent. This seems inappropriate to me since many states now set the age of majority at 18. You can vote at 18 but you can't make any decisions about your own capacity to reproduce until three years later.

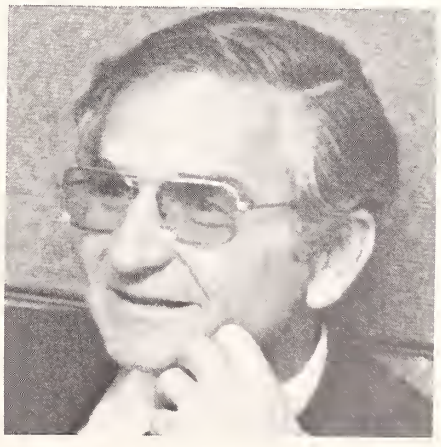
I do hope that if a mandatory consent age is required that it be 18 and that there be a mechanism for making exceptions on the basis of strong and clear medical indications.

DR. RICHMOND: Dr. Evans, I wonder if you would comment on what the profession and health care institutions might do to do a more effective job?

DR. EVANS: I strongly and sincerely believe we ought to strengthen all of our Medical Practice Boards in the states and get out the magnifying glass any time there is any question of abuse of sterilization operations or anything else for that matter.

MR. DERZON: Dr. Evans, the proposed rules that we have been discussing apply to publicly-financed patients. One of our concerns is that we treat publicly-financed patients differently than non-publicly-financed patients. Since physicians are creatures of habit and since your college seems to approve of most of these rules, can we speculate that the college will generally apply these rules across the board to the whole scale of their practice?

DR. EVANS: I think we are at the risk of developing guidelines that represent the double standard. The affluent are not concerned about this at all and so that, in effect, makes it a double standard.



DR. ALICE ROTHCHILD, chief resident in obstetrics and gynecology at Beth Israel Hospital in Boston, representing the National Women's Health Network: I would like to commend HEW for proposing regulations intended to prevent coerced sterilization. The National Women's Health Network is asking that HEW strengthen and improve the

proposed regulations as well as implement a strict enforcement policy.

The network disagrees with HEW's wording in the consent procedure and recommends that the sentence read: "A patient's consent must not be secured while the patient is in labor, during or immediately following delivery, or in conjunction with an abortion." A patient may be particularly susceptible to coercion or suggestion while under the effect of anesthesia, tranquilizers or other medication.

We recommend that the patient's consent form should be part of a booklet which the patient can take home and keep for future reference. At the top of the first page of the consent form the type of surgery to

"The rate of unnecessary hysterectomy is said to exceed 30 percent . . . A statistical review of nine years of post-partum sterilizations shows that patient regret about being sterilized runs well over 30 percent."
—Dr. Alice Rothchild

"According to HEW statistics, the rate of female sterilization increases as income level decreases among both black and white women . . . A study reported in *Family Planning Digest* indicated that 94 percent of the doctors favor mandatory sterilization of unwed

be performed should be printed clearly along with the reasons for sterilizaion.

I have heard of cases where the physician wrote "mini-lap" in order to assuage the patient's fear. The booklet should contain information on alternative methods of birth control, safety, efficacy and risks.

It is essential that all consent information be provided in the preferred language of the patient. The physician should sign that he or she has verbally explained all consent information. In cases where the physician does not speak the preferred language, a bilingual counselor should be on hand. The network recommends that the consent form be co-signed by a health professional such as a nurse or social worker.

One section in the proposed guidelines stipulates that the physician obtaining consent must certify the patient's appearance or mental competence. "Appearance" should be defined that the patient is mentally alert at the time and not under the influence of alcohol, anesthetics or medication.

A statistical review of nine years of postpartum sterilizations shows that patient regret about being sterilized runs well over 30 percent. The network recommends only two exceptions to the 30-day waiting period: (1) in instances of premature delivery where the patient has already consented prior to the eighth month of pregnancy; and (2) in instances of emergency abdominal surgery performed more than 72 hours after the signing of the initial consent form.

We support the requirement that no one under 21 years of age be sterilized with HEW funds. However, in the case of younger women who may not have access to contraception, or for whom contraceptive measures have failed, it is crucial that abortion services be available.

The sterilization of mental incompetents and retarded persons is a difficult and complex matter. The network does not find any of the alternatives in the guidelines acceptable. Thus, we recommend a continuation of the current moratorium.

We believe that hysterectomy for the sole purpose of sterilization is an inappropriate procedure, and we urge HEW to develop a separate set of regulations for hysterectomy procedures. The rate of unnecessary hysterectomy is said to exceed 30 percent.

DR. RICHMOND: I wonder whether the National Women's Health Network has developed a model pamphlet such as you describe?

DR. ROTHCHILD: We don't have such a pamphlet at this time, but we would be glad to provide you with one.

DR. HELEN RODRIGUEZ-TRIAS of the committee to End Sterilization Abuse: We believe that abuse is not only the result of coercion or lack of informed consent, but it also occurs when an individual chooses sterilization because of his or her social or economic conditions. The history and prevalence of sterilization make it clear that the social problems which affect the poor have influenced many people, particularly black, Hispanic and native American women, to be sterilized.

The present HEW policy which now reimburses up to 90 percent of the cost of sterilization while providing no funds for abortion is an example of the way in which options are limited and choices excluded.

According to HEW statistics, the rate of female sterilization increases as income level decreases among both

black and white women. A study reported in *Family Planning Digest* indicated that 94 percent of the doctors favor mandatory sterilization of unwed mothers on public assistance when they had more than three children or favored withdrawal of welfare benefits if they refused sterilization.

Certain sections of the guidelines show great improvement over HEW's prior policy, but others need to be clarified and strengthened to provide the best safeguards against abuse.

We agree with the proposed definition of sterilization, which eliminates the distinction between therapeutic and non-therapeutic procedures.

We believe that the current moratorium on sterilization of mentally incompetent individuals should be extended and expanded to cover institutionalized persons.

Consent should not be considered valid during hospitalization for childbirth, abortion or any other medical treatment.

The consent form must contain a full description of the procedure and an explanation of the benefits, alternatives, consequences and risks of the procedures, permanence, possible regret and menstrual disturbances. The form must be in the patient's pre-

mothers on public assistance when they had more than three children or favored the withdrawal of welfare benefits if they refused sterilization."
—Dr. Helen Rodriguez-Trias

"The doctor told me I needed another operation. I asked why. He said he was the doctor and that I was asking too many questions. I told him to go to hell and walked out"—Norma Ero

ferred language and should provide for evidence of the person's understanding by a statement given in his or her preferred language about the nature of the procedure.

Patients soliciting sterilization should be counseled by specially trained counselors who speak the patient's preferred language and are of the same ethnic background.

We agree that the 30-day waiting period is the minimum time necessary to permit thoughtful consideration of a decision to be sterilized. Studies have demonstrated that waiting periods serve to avoid later regret.

However, exceptions should be made in the case of premature delivery and concurrent emergency abdominal surgery.

It is clear that the best formulated guidelines are merely words on paper without strict monitoring. HEW has fallen short with its monitoring. Contracts can be given to local agencies and bodies which already monitor medical practices to watchdog sterilization practices.

NORMA ERO, age 25, mother of three children: A tragedy happened to me at Lincoln Hospital of New York City last year.

I went there for a PAP test on or about December 26, 1976. The doctor told me that everyone who had an ectopic pregnancy should have a tubal ligation. I had an ectopic pregnancy the year before. The doctor asked why I didn't want a tubal ligation. I said I wanted at least one more child as a playmate for my daughter. The doctor told me they could put tubes back together again by surgery any time I wanted, so I had the tubal ligation on January 14, 1977.

I learned later that New York law required a 30-day waiting period between consent and operation. After the operation, while still in the hospital, I started having abdominal pains. The doctor told me I would need a hysterectomy within two months and 10 years after the tubal ligation.

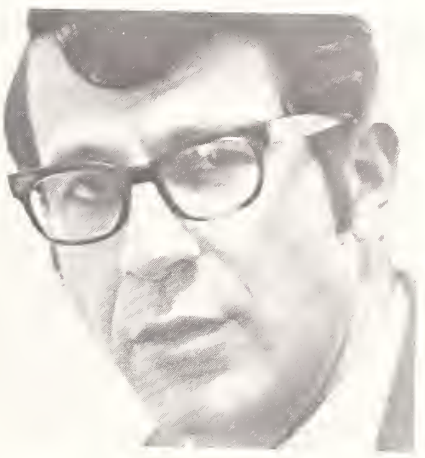
This conversation took place five days after the tubal ligation. I came back in February and then in March. The doctor kept talking about a hysterectomy. He called me at home at least once a week insisting that I would need a hysterectomy.

I became very worried and told the doctor to please tell me if I had cancer — that I could take it. The doctor said that if I wanted to see my children grown up I should have this operation. I asked what was wrong with me. He answered that it is a doctor's privilege not to tell me exactly what I had. I was even more scared and went home crying. I had a hysterectomy on May 25th, 1977. Afterwards I was told I had a cyst on one ovary, and I got very sick.

They said they took out the bad ovary and also my appendix. After surgery I was afraid to tell the people I had a hysterectomy because I thought I had cancer. I went back to Lincoln Hospital in September. The doctor told me I needed another operation. I asked why. He said he was the doctor and that I was asking too many questions. I told him to go to hell and walked out.

Then I was told by a hospital committee that my hysterectomy was unjustified along with three other hysterectomies done in May and June. I felt terrible and got very depressed. Later I decided to speak out and help other women who may go through the same thing.

On November 21, 1977 I had an operation at Mt. Sinai Hospital. They removed what was left — the other ovary which had a large cyst on it.



DR. SIDNEY WOLFE of the Public Citizen's Health Research Group: What happened to Mrs. Ero happens on a massive basis, particularly among the black and Hispanic women in this country.

We applaud many of the things that are in the regulations as major steps forward, but strongly object to the failure of HEW to require mandatory second opinions for all so-called non-sterilization hysterectomies. We also note a continuing lack of enforcement in existing regulations.

Hysterectomy is one of the most rapidly increasing kinds of surgery in the United States, with the rate of hysterectomies having increased 30 percent from 1965 to 1975. In 1975, 725,000 of these operations were performed.

Although it has been said that a major reason for this increase has been for sterilization purposes, there is no published national data on this.

We have obtained data from an unpublished HEW study which shows that: (1) about one out of five hysterectomies, or 150,000 a year, are done for sterilization and; (2) hysterectomies on black women are al-

"By disallowing reimbursement for hysterectomies done for sterilization, HEW is virtually encouraging doctors to state that the basis for the procedure is for medical disease rather than for contraceptive purposes . . . To avoid the detailed informed consent procedures and insure they will be paid, many doctors will again use contrived medical justification for what are actually sterilizations."—Dr. Sidney Wolfe

"It is our experience that even the clearest and kindest of social workers, doctors and health workers can be misunderstood, mistrusted and feared by consumers . . . Generally, we support the idea that mentally incompetent people, who cannot understand what sterilization is, should not be sterilized."—Kathy Miller

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most three times more likely to be done for sterilization than are hysterectomies on white women.

By disallowing reimbursement for hysterectomies done for sterilization, but not requiring a second opinion for other hysterectomies, HEW is virtually encouraging doctors to state that the basis for the procedure is for disease rather than for contraceptive purposes. To insure they are paid, many doctors will again use contrived medical justification for sterilizations.

Requiring a second surgical opinion in all cases of hysterectomy would: (1) Stop physicians from misstating the purpose of the hysterectomy; and (2) set an important precedent which would lead to mandatory second surgical opinions for other federally-funded operations.

By not requiring a second opinion for all hysterectomies, HEW greatly weakens the impact on prohibiting funds for sterilization hysterectomies.

The consent procedure outlined in the proposed Federal regulations would assure that patients give truly informed, voluntary consent for sterilization only if they are conscientiously implemented by physicians and other personnel. Given the history of coercion and abuse in this area, we believe that a more comprehensive educational approach must be used.

KATHY MILLER of the North Central Philadelphia Community Mental Health/Mental Retardation Center, representing the National Association of Social Workers: We were very pleased to see the thoughtfulness that has gone into these regulations.

I have a few suggestions about some specific points. We support the

definition of sterilization that has been set forth. However, we would like it stated more plainly that the contraceptive hysterectomy should not be funded.

The individual who seeks a hysterectomy should be told early in writing that it will render her permanently incapable of reproducing. We would like to see the physician document that he has made that explanation. We endorse the 30-day waiting period and also the minimum age of 21.

The consent procedures are in general excellent, but we would like to suggest a few additions. It is our experience that even the clearest and kindest of social workers, doctors and health workers can be misunderstood, mistrusted and feared by consumers.

We would like to see sterilization and birth control information always presented orally and in writing in a person's primary language, and for a family member or friend to be able to come with the patient through all the discussions and signing.

The metal incompetency section has certainly been the most difficult to talk about, since it is not defined and the definitions differ in each state. Generally, we support the idea that mentally incompetent people who cannot understand what sterilization is should not be sterilized.

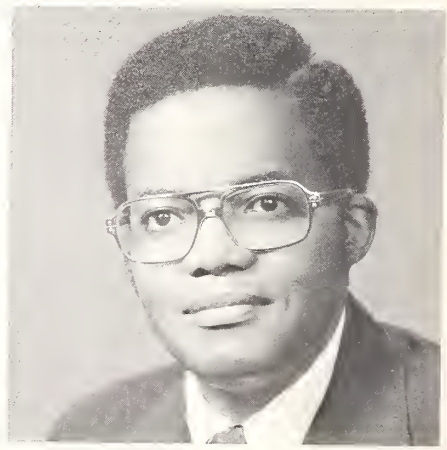
On enforcement, we would like to see periodic reports and audits required in sterilizations and have the results published.

DR. LASHOFF: We have obviously been struggling over the mental incompetence point. Have you and your colleagues found circumstances where nonsterilization has created a hardship and really interfered with the care of the retarded?

MS. MILLER: Very few. I think people who are mildly retarded can probably think it through.

MR. LIBASSI: Let me press this a little bit further. Is it your feeling that the moratorium has reduced instances of sterilization abuse of mentally retarded persons?

MS. MILLER: Yes. I believe that is definitely true from talking to a number of poeple who have worked in the field for a long time.



DR. HENRY FOSTER, representing Planned Parenthood Federation of America, chairman of the De-

"For the mentally incompetent, we feel the review committee suggested by HEW should be expanded to include a patient advocate that can identify with the patient on the basis of race, ethnic background, sex and age."—Dr. Henry Foster

"For reproductive freedom to exist, we believe two conditions have to be fulfilled. First there has to be an atmosphere of freedom within which informed decisions have to be made; and second, each individual has to have access to an affordable means of contraception including voluntary sterilization."—Peters Wilson

partment of Obstetrics and Gynecology at Meharry Medical College in Nashville and chairman of the executive committee of the OBGYN section of the National Medical Association: The Federation and I are in accord with the 30-day waiting period.

We totally support separating sterilization decisions from any stressful situation such as surgery or childbearing, however, there are two conditions under which we would like to recommend consideration for waivers.

There are circumstances, such as, ectopic pregnancy and repeated cesarean sections, where it is appropriate for a patient to make a decision regarding sterilization, prior to any medication.

We question the ethics and propriety of causing a patient to have a second major surgical procedure with its attendant risk and the risk of a second anesthesia.

We feel if a person has signed a sterilization consent form and goes into premature labor or requires some sort of surgical procedure before the 30-day waiting period is up, then that person should be allowed to sign a second statement confirming the intent in the previous statement and receive a waiver. This should be done without medication. We feel that there should be some time limit after which a consent becomes invalid, possibly six months.

We do not agree with the absolute minimum age of 21 years. We recognize some unusual circumstances where persons under 21 may have legitimate cause for requesting sterilization, particularly where patients may have had four or five infants by age 20.

For the mentally incompetent, we feel the review committee suggested by HEW should be expanded to include a patient advocate that can identify with the patient on the basis of race, ethnic background, sex and age.

For the severely mentally impaired, the Federation feels that the matter would best be referred to the National Commission for the Protection of Human Subjects.

PETERS WILSON, representing Zero Population Growth: The proposed sterilization regulations attempt to answer the question, "How do you guarantee reproductive freedom?" Reproductive freedom is a fundamental concern to ZPG.

For reproductive freedom to exist, we believe two conditions have to be fulfilled. First, there has to be an atmosphere of freedom within which informed decisions have to be made; and second, each individual has to have access to an affordable means of contraception, including voluntary sterilization. Neither of these conditions is satisfactory for all Americans.

We make three recommendations with regard to the implementation of the regulations. First, it would be helpful to groups outside HEW to understand the criteria used in evaluating an enforceable regulation. HEW has justified its decision to allow no exceptions to the 30-day waiting period because it says they are not enforceable. But it has not explained why.

Second, we recommend that HEW develop an education strategy that will educate both the potential patients and the providers of the services about the regulations.

Third, we recommend development of a specific monitoring strategy. The Inspector General of HEW now plans to conduct audits in at least five states during this fiscal year as a part of the effort to evaluate compliance with the

regulations. However, the audits may not result in an effective assessment of whether some individuals who seek sterilizations are turned away.

We urge HEW to again look at its regulations from the standpoint of particular groups of people, such as rural residents, and how they may be affected by the regulations as opposed to "ideal" patients or "average" patients.

According to the Public Health Service, although close to a third of the nation's population lives in nonmetropolitan and rural communities they are served by only 12 percent of the nation's physicians. According to a 1976 report from the Alan Guttmacher Institute, roughly three out of 10 nonmetropolitan communities have no organized family planning service. And of those which do have services, nine out of 10 have only one source.

MR. LIBASSI: I think the suggestions from persons of all points of view have been extremely helpful and I want to thank all of you for your efforts, expecially those who have traveled distances and taken the time to prepare statements. The quality of this hearing has been very impressive.

Super Salesmen Make EPSDT Work in Pennsylvania.

by John C. Miller

This is the second in a series of articles about successful techniques used by states in operating their Early and Periodic Screening, Diagnosis and Treatment Programs.

Dale Carnegie probably couldn't have been more successful at influencing physicians and dentists to enlist in the EPSDT Program than the Pennsylvanians who sold them on it.

Like all good sales campaigns, the Pennsylvania plan provided for reselling the providers and keeping them sold on participating in the program. As a result, fewer than one percent of the 800 physicians and dentists that signed up have resigned.

Since the first child was examined under the EPSDT program in 1973, the number of children receiving examinations has risen from 42,000 in 1974 to 115,000 in 1975, leveling out in 1976 at 176,000. A recent study of nine states showed that Pennsylvania was the most successful state at insuring that children received treatment for problems. Pennsylvania's treatment rate was 88 percent compared with an average of 78 percent for the other states. The study also showed the state had fewer children who did not report for examination or treatment than other states.

"From the beginning we concentrated on organizing the delivery system because we knew we could not assume that the medical providers would participate, particularly at the rates of reimbursement offered," says James McKittrick, EPSDT project director for Pennsylvania.

Since EPSDT was a completely new program, it was decided that successful recruitment would depend on a well planned sales campaign. The task of selling physicians and dentists was assigned to two contractors with broad experience in the health care field. The responsibility for finding children eligible for the program was assigned to the state's county boards of assistance in all but two of the state's counties.

Selling providers

EPSDT planners decided that the complexity of the program required that physicians and dentists be contacted personally about joining the program rather than simply sending a letter or telephoning. To make the contacts, the two contractors used persons who were familiar with the work flow of physician and dental offices, such as former nurses and drug salesmen. The recruiters received training in the EPSDT program and were cautioned to be low-key.

A sales call consisted of explaining the benefits of the program to children, the fact that no provider would be overburdened, the relatively fast reimbursement procedure, and recommendations on how the examination and treatment process might be set up to flow most smoothly.

Since Government paperwork has a reputation for being time consuming, recruiters were cautioned to stress the points that their computerized billing system would insure that reimbursement would be prompt. Recruiters offered personnel to assist the office staff in setting up a system for efficiently ushering the children through the examination and treatment process, and provided a detailed explanation of the paperwork procedure.

Every few months recruiters make return visits to the providers they enlisted and discuss problems that may have developed. If a computer printout shows that a physician's invoices are repeatedly rejected for the same reason, the recruiter brings that to the physician's attention.

The computer also spots inconsistencies. For example, one physician was finding eight times as many hearing problems as the average physician in the state. When a recruiter informed him about it, he had the audiometer checked and found it to be defective.

"From time to time, irritants occur in the best systems," says Mr. McKittrick, "so regular visits by the persons who recruited the physicians or dentists is a definite plus in our program. It sometimes just helps to have someone representing the program to tell your troubles to even though there is no real solution."

While the physicians try to treat all problems found during their examination, some cases call for referrals to specialists. "We manage to get physicians to refer about 60 percent of the patients to specialists, a percentage which generally is not achieved," says Mr. McKittrick. "During the past year, examining physicians occassionally were unable to make referrals to a few specialties, such as for eye care.

"To solve this, representatives of the contractors visited specialists and told them they would not be over burdened with patients. If, for instance, during the average month there are 18 children in the county referred for a certain speciality, each specialist would be asked to take a few cases. The response was very good because they realized they would not be overburdened with hoards of children."

In the Philadelphia area, where there is a high concentration of children eligible for the program, it was found that the "little at a time" approach worked best. "We began by asking physicians to make just five examinations a month and, as they found their fears of problems did not

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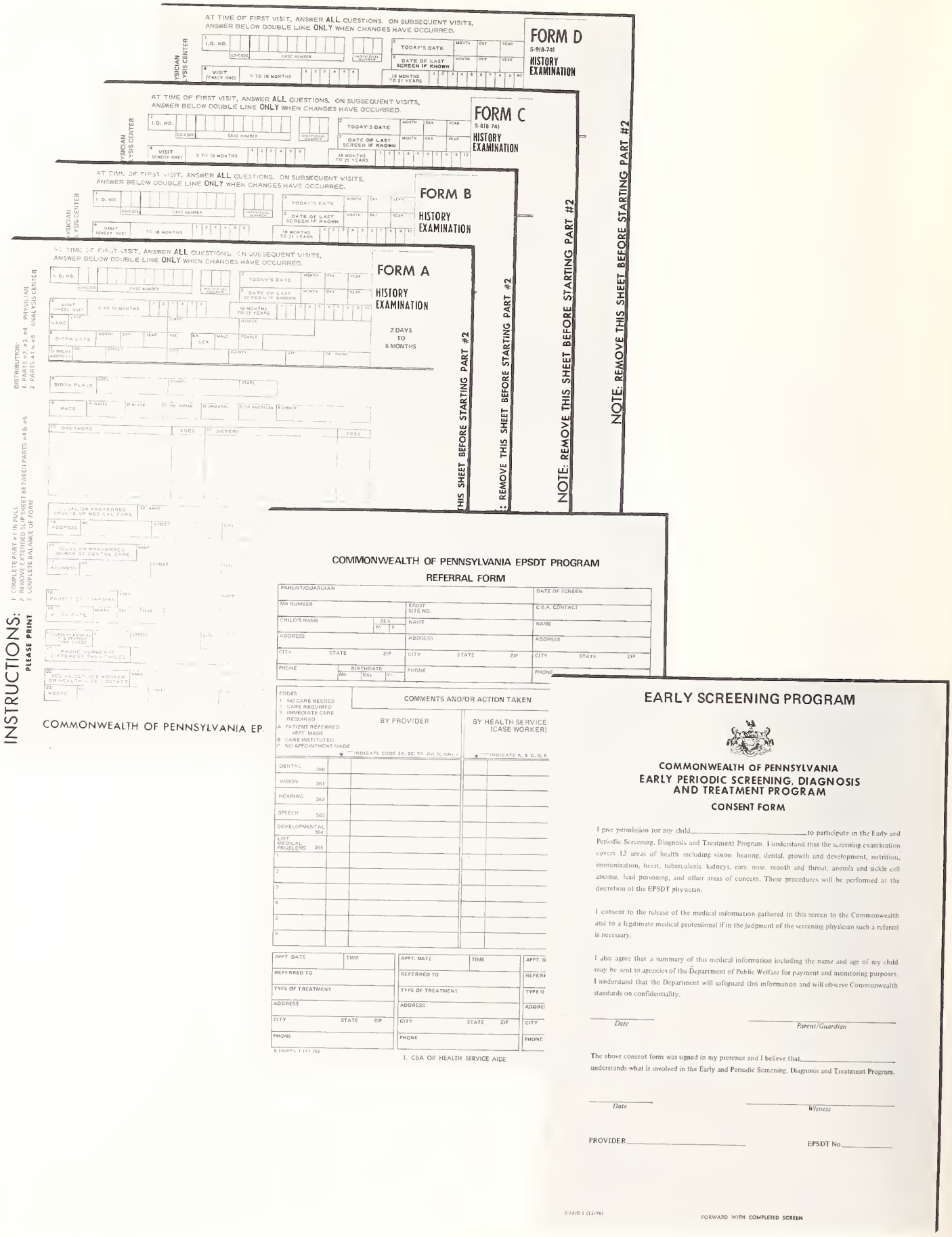
John Miller is a freelance writer specializing in the health care and social services field.



AT TIME OF FIRST VISIT, ANSWER ALL QUESTIONS. ON SUBSEQUENT VISITS, ANSWER BELOW DOUBLE LINE ONLY WHEN CHANGES HAVE OCCURRED.

FORM D
S-9(8-74)
HISTORY EXAMINATION

FORM C
S-8(8-74)
HISTORY EXAMINATION

FORM B
HISTORY EXAMINATION

FORM A
HISTORY EXAMINATION
2 DAYS TO 6 MONTHS

NOTE: REMOVE THIS SHEET BEFORE STARTING PART #2

DISTRIBUTION:
1. PARTS #2, #3, #4 PHYSICIAN
2. PARTS #1 & #5 ANALYSIS CENTER

INSTRUCTIONS:
PLEASE PRINT
1. COMPLETE PART #1 IN FULL
2. REMOVE EXTENDED SLIP SHEET BETWEEN PARTS #1 & #5
3. COMPLETE BALANCE OF FORM

COMMONWEALTH OF PENNSYLVANIA EP

COMMONWEALTH OF PENNSYLVANIA EPSDT PROGRAM
REFERRAL FORM

PARENT/GUARDIAN | DATE OF SCREEN
MA NUMBER | EPSDT SITE NO. | C.B.A. CONTACT
CHILD'S NAME | SEX M F | NAME | NAME
ADDRESS | ADDRESS | ADDRESS
CITY STATE ZIP | CITY STATE ZIP | CITY STATE ZIP
PHONE | BIRTHDATE Mo Day Yr. | PHONE | PHONE

CODES
1 NO CARE NEEDED
2 CARE REQUIRED
3 IMMEDIATE CARE REQUIRED
A PATIENT REFERRED APPT MADE
B CARE INSTITUTED
C NO APPOINTMENT MADE

COMMENTS AND/OR ACTION TAKEN

	BY PROVIDER (INDICATE CODE 2A, 2C, 3A, OR 3C ONLY)	BY HEALTH SERVICE (CASE WORKER) (INDICATE A, B, C, 0, 8)
DENTAL 360		
VISION 361		
HEARING 362		
SPEECH 363		
DEVELOPMENTAL 364		
LIST MEDICAL PROBLEMS 365		
1		
2		
3		
4		
5		
6		

APPT. DATE | TIME
REFERRED TO
TYPE OF TREATMENT
ADDRESS
CITY STATE ZIP
PHONE

S-10/PT-1 (11/76)

1. CBA OR HEALTH SERVICE AIDE

EARLY SCREENING PROGRAM

COMMONWEALTH OF PENNSYLVANIA
EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM
CONSENT FORM

I give permission for my child_____to participate in the Early and Periodic Screening, Diagnosis and Treatment Program. I understand that the screening examination covers 13 areas of health including vision, hearing, dental, growth and development, nutrition, immunization, heart, tuberculosis, kidneys, ears, nose, mouth and throat, anemia and sickle cell anemia, lead poisoning, and other areas of concern. These procedures will be performed at the discretion of the EPSDT physician.

I consent to the release of the medical information gathered in this screen to the Commonwealth and to a legitimate medical professional if in the judgment of the screening physician such a referral is necessary.

I also agree that a summary of this medical information including the name and age of my child may be sent to agencies of the Department of Public Welfare for payment and monitoring purposes. I understand that the Department will safeguard this information and will observe Commonwealth standards on confidentiality.

_____ Date

_____ Parent/Guardian

The above consent form was signed in my presence and I believe that_____understands what is involved in the Early and Periodic Screening, Diagnosis and Treatment Program.

_____ Date

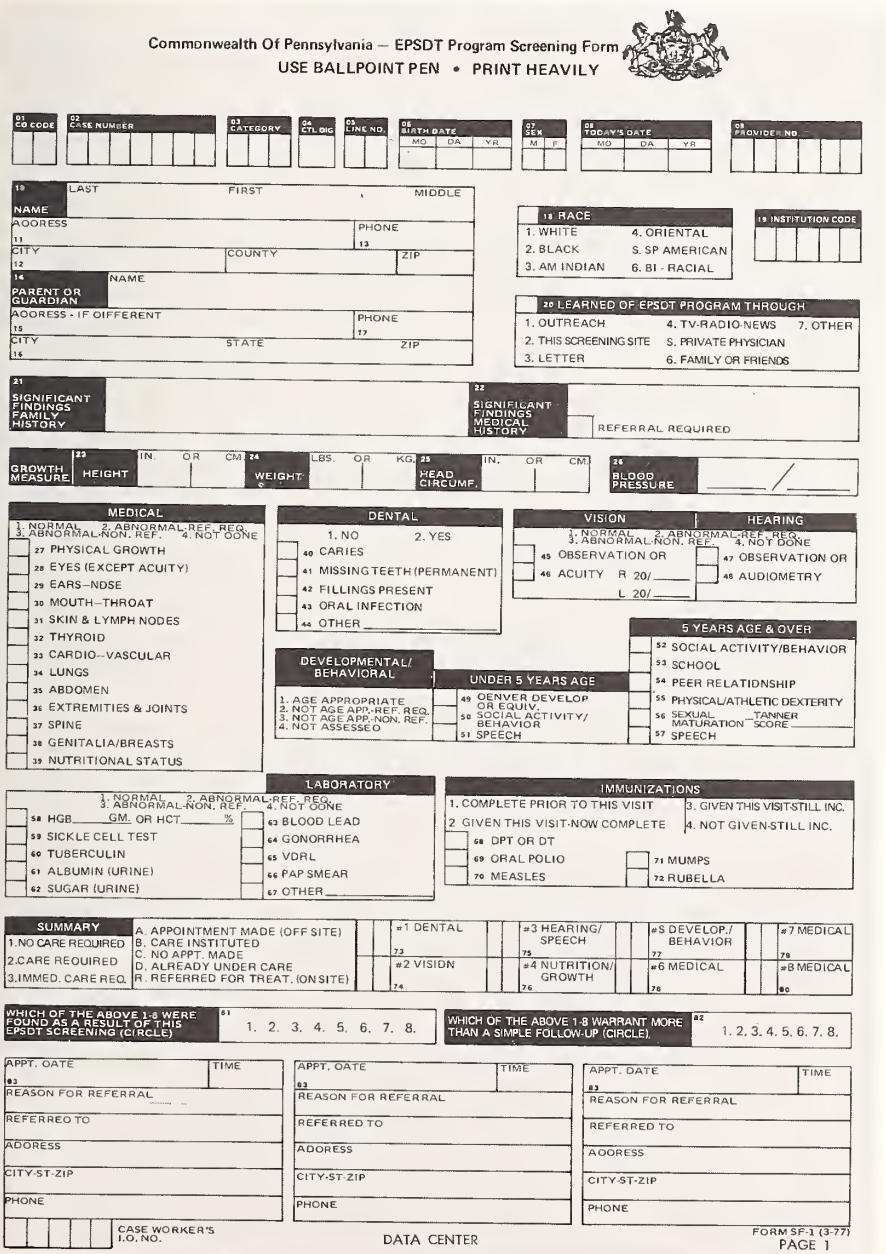
_____ Witness

PROVIDER_____ EPSDT No._____

S-10/C-1 (11/76)

FORWARD WITH COMPLETED SCREEN

Consolidation of Forms Speeds Paperwork.



Commonwealth Of Pennsylvania — EPSDT Program Screening Form
USE BALLPOINT PEN • PRINT HEAVILY

01 CO CODE | 02 CASE NUMBER | 03 CATEGORY | 04 CTL DIG | 05 LINE NO. | 06 BIRTH DATE MO DA YR | 07 SEX M F | 08 TODAY'S DATE MO DA YR | 09 PROVIDER NO.

10 NAME LAST FIRST MIDDLE
ADDRESS 11 PHONE 13
CITY 12 COUNTY ZIP
14 PARENT OR GUARDIAN NAME
ADDRESS - IF DIFFERENT 15 PHONE 17
CITY 16 STATE ZIP

18 RACE
1. WHITE 4. ORIENTAL
2. BLACK 5. SP AMERICAN
3. AM INDIAN 6. BI - RACIAL

19 INSTITUTION CODE

20 LEARNED OF EPSDT PROGRAM THROUGH
1. OUTREACH 4. TV-RADIO-NEWS 7. OTHER
2. THIS SCREENING SITE 5. PRIVATE PHYSICIAN
3. LETTER 6. FAMILY OR FRIENDS

21 SIGNIFICANT FINDINGS FAMILY HISTORY
22 SIGNIFICANT FINDINGS MEDICAL HISTORY REFERRAL REQUIRED

GROWTH MEASURE: 23 HEIGHT IN. OR CM. | 24 WEIGHT LBS. OR KG. | 25 HEAD CIRCUMF. IN. OR CM. | 26 BLOOD PRESSURE ____/____

MEDICAL (1. NORMAL 2. ABNORMAL-REF. REQ. 3. ABNORMAL-NON. REF. 4. NOT DONE)
27 PHYSICAL GROWTH
28 EYES (EXCEPT ACUITY)
29 EARS—NOSE
30 MOUTH—THROAT
31 SKIN & LYMPH NODES
32 THYROID
33 CARDIO—VASCULAR
34 LUNGS
35 ABDOMEN
36 EXTREMITIES & JOINTS
37 SPINE
38 GENITALIA/BREASTS
39 NUTRITIONAL STATUS

DENTAL (1. NO 2. YES)
40 CARIES
41 MISSING TEETH (PERMANENT)
42 FILLINGS PRESENT
43 ORAL INFECTION
44 OTHER

VISION (1. NORMAL 2. ABNORMAL-REF. REQ. 3. ABNORMAL-NON. REF. 4. NOT DONE)
45 OBSERVATION OR
46 ACUITY R 20/____ L 20/____

HEARING (1. NORMAL 2. ABNORMAL-REF. REQ. 3. ABNORMAL-NON. REF. 4. NOT DONE)
47 OBSERVATION OR
48 AUDIOMETRY

DEVELOPMENTAL/BEHAVIORAL (1. AGE APPROPRIATE 2. NOT AGE APP.-REF. REQ. 3. NOT AGE APP.-NON. REF. 4. NOT ASSESSED)

UNDER 5 YEARS AGE
49 DENVER DEVELOP OR EQUIV.
50 SOCIAL ACTIVITY/BEHAVIOR
51 SPEECH

5 YEARS AGE & OVER
52 SOCIAL ACTIVITY/BEHAVIOR
53 SCHOOL
54 PEER RELATIONSHIP
55 PHYSICAL/ATHLETIC DEXTERITY
56 SEXUAL MATURATION — TANNER SCORE
57 SPEECH

LABORATORY (1. NORMAL 2. ABNORMAL-REF. REQ. 3. ABNORMAL-NON. REF. 4. NOT DONE)
58 HGB____GM. OR HCT____%
59 SICKLE CELL TEST
60 TUBERCULIN
61 ALBUMIN (URINE)
62 SUGAR (URINE)
63 BLOOD LEAD
64 GONORRHEA
65 VDRL
66 PAP SMEAR
67 OTHER

IMMUNIZATIONS (1. COMPLETE PRIOR TO THIS VISIT 2. GIVEN THIS VISIT-NOW COMPLETE 3. GIVEN THIS VISIT-STILL INC. 4. NOT GIVEN-STILL INC.)
68 DPT OR DT
69 ORAL POLIO
70 MEASLES
71 MUMPS
72 RUBELLA

SUMMARY
1. NO CARE REQUIRED
2. CARE REQUIRED
3. IMMED. CARE REQ.
A. APPOINTMENT MADE (OFF SITE)
B. CARE INSTITUTED
C. NO APPT. MADE
D. ALREADY UNDER CARE
R. REFERRED FOR TREAT. (ON SITE)

#1 DENTAL 73 | #2 VISION 74 | #3 HEARING/SPEECH 75 | #4 NUTRITION/GROWTH 76 | #5 DEVELOP./BEHAVIOR 77 | #6 MEDICAL 78 | #7 MEDICAL 79 | #8 MEDICAL 80

81 WHICH OF THE ABOVE 1-8 WERE FOUND AS A RESULT OF THIS EPSDT SCREENING (CIRCLE) 1. 2. 3. 4. 5. 6. 7. 8.
82 WHICH OF THE ABOVE 1-8 WARRANT MORE THAN A SIMPLE FOLLOW-UP (CIRCLE) 1. 2. 3. 4. 5. 6. 7. 8.

APPT. DATE 83 | TIME
REASON FOR REFERRAL
REFERRED TO
ADDRESS
CITY-ST-ZIP
PHONE

APPT. DATE 83 | TIME
REASON FOR REFERRAL
REFERRED TO
ADDRESS
CITY-ST-ZIP
PHONE

APPT. DATE 83 | TIME
REASON FOR REFERRAL
REFERRED TO
ADDRESS
CITY-ST-ZIP
PHONE

CASE WORKER'S I.D. NO.
DATA CENTER
FORM SF-1 (3-77)
PAGE 1

The front page of the new form, at left, incorporates the old examination, referral and consent forms, shown on the facing page.

The examination form was condensed by eliminating a number of patient history questions that did not pertain to problems detected and the consent form was placed on the back.

Consolidation of forms helped overcome the legendary resistance to Government redtape not only by reducing the number of forms required to be filled out by the physician from three to one, but by shaving three minutes from the 15 it took to complete the three forms. In addition, the single form appears less formidable to the physician being recruited.

The single form also assures that all necessary information is forwarded to the state EPSDT office. Under the old system, the state would reimburse physicians upon receipt of a properly completed examination form. Frequently, the parental consent and physician referral forms were not sent in with the examination form and considerable effort was required to have them returned. ■

materialize and their checks came in quickly, they became willing to take more children," says Rosetta Smith who coordinates the EPSDT program in Philadelphia and its four neighboring counties under contract with the state.

"Before the EPSDT program, physicians had been accustomed to waiting about six months to be reimbursed through various public programs," recalls Ms. Smith, "so when the first check arrived within two months and they found the children didn't disrupt their offices and didn't arrive raggedy, they began to warm up to the program.

"We showed them how they could hire a part-time person to assist with the paperwork and use less of their valuable time, with the result of being more effective and more profitable.

"At first we received 25 to 30 complaints a month from parents who said the physicians didn't treat them properly or did not perform, say, a hearing examination. Now, the complaints are down to one a month and we are receiving compliments, which we feel is quite a turnaround."

What at first appeared to be a major problem in recruiting physicians was a requirement that they provide a hearing test as part of the examination package. A great many physicians lacked an audiometer, which is necessary for the hearing test. Resistance to purchasing an audiometer faded, however, when recruiters explained that at the rate of $24 per examination, physicians could pay for the device in a short time.

Mr. McKittrick finds that often when dentists decline to participate in the program "due to low reimbursement rates," professional pride causes them to change their minds. "When a dentist turns us down, we tell him quite honestly that we will probably have to bring in a dentist from another county to take care of the welfare kids. Frequently, we receive a call from him later saying that he will do his part to take care of the kids. Often, the dentists mention that it just wouldn't look right not to take care of the kids in the county."

In 14 of the state's 67 counties, it is very difficult to recruit dentists. To solve the problem, the state bought a van equipped with a mobile dental office. It is staffed with a dentist who works for himself, a dental hygienist and a dental assistant. The van makes a circuit of the counties according to a schedule of appointments worked out by the County Boards of Assistance.

Recently county dental associations have agreed to refer problems to their members once the children receive remedial services. As Mr. McKittrick explains it, the reimbursement for remedial work is substantially lower than the average fee they receive, but the reimbursement for cleaning and floride treatments is not.

Many potential problems in developing the provider network were avoided through advice from the program's Medical Advisory Committee which is composed of 20 practicing physicians and chaired by a physician who is editor-in-chief of a leading medical journal. "The committee has given us a lot of credibility," says Mr. McKittrick. "Not only does it help us clarify regulations, but if we have a problem they will go in and discuss it with a physician or the administrator of a hospital. The committee is an extremely valuable asset."

Finding patients

County welfare offices have the responsibility for finding children who are eligible for examination and treatment in all except the most densely populated areas—the counties which surround Philadelphia and Pittsburgh.

Early on in the planning, it was decided that the County Boards of Assistance could not be staffed to handle the 220,000 children in Philadelphia area or the 65,000 in Pittsburgh's Allegheny County, so the task for finding children eligible for the program was assigned to the same two contractors who recruit providers. The contractors are the Philadelphia Health Management Corporation and the Health Screening Research Foundation of Pittsburgh.

Rosetta Smith, EPSDT coordinator for the Philadelphia area, at first used the textbook approach to find eligible children, but began to change her tactics as she became more street wise. At the beginning of the program Ms. Smith recruited mothers "for the mother-grandmother image" to sign up children for examination and treatment. She gave them intensive training in salesmanship and, by way of motivation, explained the results they could expect to achieve in the general level of health in the U.S. if they were successful.

"They did well enough, but we began to realize they were overtrained," recalls Ms. Smith. "They were too full of facts and figures that really had little appeal to the mothers they were selling the program to. We needed a gimmick to appeal to the mothers, so we cut the training from three weeks to two days and developed the slogan, 'You can't play if you aren't healthy.' "

Since the concept of preventive medicine was virtually unknown to the parents, it was necessary to sell them on the program. Caseworkers found that for every three parents who would participate in the program one would simply point to her apparently healthy children and ask why it was necessary.

The great majority of the children signing up for examinations were young, with only a few teenageers. In an effort to reach the older children, young men were hired because they could relate better to the older children. At first they were outfitted in uniforms, but the dress code was changed to civilian clothing with ties, and finally to bluejeans.

Case recruitment is performed by 17 teams, each composed of a coordinator, clerk and from five to eight salesmen. They are successful at selling the parents on the program and having the children examined between 75 and 80 percent of the time.

Caseworkers were taught to use both the hard sell and the soft sell approaches, but cautioned to use the hard sell only when the mother was not under stress. They were told that if they encountered a harassed mother, it was better to return the next day. Sometimes, caseworkers would find they had arrived at the wrong time, such as during a favorite soap opera. In that case, they would

try to sell the program during commercials.

The sales pitch runs between five and 15 minutes, depending on the distractions in the home. To close the sale, the caseworkers pulls out a list of physicians with times when each is available. The mother is asked to choose the physician and then the time that suits her best. "At first our people would suggest an appointment and time, and assume the mother would keep it once she made the commitment," said Ms. Smith. However, our no-show rate decreased considerably when we began to show her a full range of alternatives and explore the possibility of other activities which might prevent her from keeping the appointment."

One surprising reaction of mothers was that they usually did not choose the closest physician, but one some distance from her neighborhood. Caseworkers learned this was because they did not want neighbors to think their child had a defect.

Another major factor influencing the no-show rate was the quota set for staff members. At first the quota was 15 sales daily, but this was later switched to 150 every two weeks. This relieved the pressure to make 15 sales each and every day no matter what, and allowed them to return when the mother was in a more receptive frame of mind.

The result of these changes increased the rate of examinations to house calls between 35 and 52 percent, depending on the area visited.

Caseworkers offer to pay the expense of transportation and accompany the family to the physician's office for examination and treatment. Public transportation is augmented in the Pittsburgh area by a mini bus which shuttles about 300 children a month to physicians.

"If there is a key to this program it is in presenting precise information honestly, but with a little salesmanship," says Mr. McKittrick. "We are very proud that, with the help of the providers, we have been able to examine more than a half million children while reducing the administrative cost of the program by 30 percent over the past three years." ■

Publications and Films

Please address all inquiries and requests for publications and films to the addresses in the listings. Items for review should be sent to Theresa Williams in care of this magazine.

Managing Institutional Planning: Health Facilities and PL 93–641. Martin S. Perlin. Aspen Systems Corporation, 20010 Century Boulevard, Germantown, MD 20767. $15.00

A how-to handbook that describes the planning structures, processes and methods which are being used successfully by health care institutions. The book explains how to:

- Demonstrate commitment to planning and secure meaningful involvement by key decision makers.
- Resolve differences and disputes before they become issues for open debate at the board planning level.
- Contain construction costs.
- Conduct community surveys.
- Select and use the right planning consultant.
- Judge the capacity of an existing facility to respond to projected changes in patient demand.
- Analyze departmental location and relationship through the use of a matrix chart.
- Analyze how changes in population size and composition will affect your institution.
- Evaluate future space requirements based on existing or projected volume of services.

Health Planning—A Systematic Approach. Dr. Herbert H. Hyman. Aspen Systems Corporation, 20010 Century Blvd., Germantown, MD 20767. $19.95.

Health Planning shows how theoretical methods and concepts of health planning are actually practiced, the mistakes made and how to avoid them.

It not only contains many of the "hows" of planning, but the real-life constraints and problems which arise, so that prospective planners will have no illusions about what they are getting into.

Counseling the Older Adult. Richard H. Davis, Ph.D., Publications Office, Andrus Gerontology Center, University of Southern California, University Park, Los Angeles, 90007. $6.50 plus 35¢ postage & handling.

A training manual for use by professionals, paraprofessionals and beginning counselors as a guide in providing help to older adults.

Included in this book are readings which summarize important information about aging and about the common problems older adults encounter for which they request counseling services.

The Problems and Promises of Medicaid. Emily Friedman, American Hospital Association, 840 North Lake Shore Drive, Chicago, 60611. $2.50.

Contains five articles that review how Medicaid began, analyze its escalating costs, compare several state programs, present the views of Medicaid officials and hospital administrators, and discuss prospects for the future.

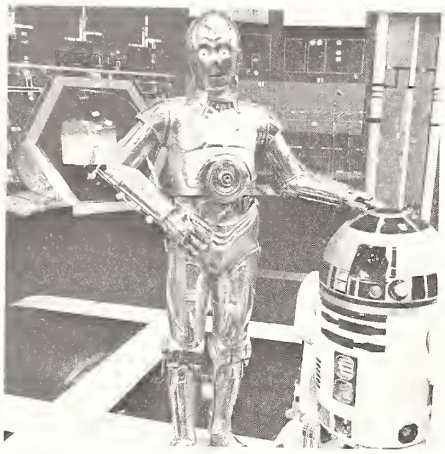
Drug Users and Emergent Organizations. Harvey A. Moore, The University Presses of Florida, 15 N.W. 15th Street, Gainesville, Florida 32603. $4.50.

A study about the growth and development of three organizations, each of which is part of a community-wide response to the rising awareness of adolescents' use of drugs.

The evolution of the delivery of services to clients is examined by describing the development of agency-client relationships.

Cutting Loose: An Adult Guide to Coming To Terms With Your Parents. Howard M. Halpern, Ph.D., Bantam Books, 666 Fifth Avenue, New York, 10019. $2.25.

Offers concrete, practical advice—leavened with a sense of humor—on how to break out of the family's magnetic field and approach parents as one adult to another.



Children's heroes enter war against childhood diseases.

The mechanized stars of Star Wars, R2-D2 and C3PO, are teaming up with television's venerable Captain Kangaroo to dramatize HEW's campaign against the seven preventable childhood diseases.

The robots and the captain will be seen on television commercials, for which public service time is being donated. Magazines and newspapers will carry public service ads, and the message will be heard on radio as well as appearing on transit cards in subways and buses.

The campaign was launched in April, 1977 by HEW Secretary Joseph A. Califano, Jr., when he noted that 20 million children were not immunized against the seven diseases and termed it a "national disgrace." An indication of the campaign's success is found in a survey conducted during the last quarter of 1977 which showed that the incidence of measles fell 65 percent below the same period in 1976. A survey covering the first three months of 1978 showed the same decline in the incidence of the disease.

A second objective of the campaign is to establish a permanent system to provide comprehensive immunization for the three million children born in the U.S. each year. Substantial progress is being made in realizing this goal due to the cooperation of medical and social services organizations throughout the country.

HCFA Receives Awards.

The Health Care Financing Administration received awards for exceptional achievement and effectiveness in operating its programs at the annual HEW awards ceremony held recently in Washington.

The agency received two of the three highest awards from Secretary Joseph A. Califano, Jr., for:

- Improved design of the quality control system for Medicaid which will result in an estimated $275 million annual savings in Federal funds. The award was received by Dr. Victor I. Kugajevsky, acting deputy assistant director of the Medicaid Bureau's Office of Financial Management.
- Reduction of fraud and abuse in the Medicaid program, an award shared by HCFA's Project Integrity Work Group and HEW's Office of the Inspector General.

The agency also received two of seven management awards presented by the Secretary.

Increase in premiums for Medicare due July 1.

The monthly premium for Medicare's supplemental medical insurance will increase 50 cents to $8.20, beginning July 1. This represents a 5.9 percent increase, the same rate at which social security benefits increased during 1977. (Except for this protective feature of the Medicare law, which limits increases in the medical insurance premium to the previous year's rate of increase in social security benefits, the increased costs of the program would have required a premium of $13.40.)

At the same time, about 21,000 elderly persons who are not automatically eligible for the hospital insurance part of the Medicare program, but voluntarily enroll in it, will pay an extra $9 per month for coverage, their premium rising to $63.

Noting that the premium for voluntary hospital coverage and the deductible for Medicare hospital insurance have doubled since 1973, HEW Secretary Joseph A. Califano, Jr., said: "This latest mandated increase is further evidence of the need for action on the Administration's hospital cost containment bill to provide the American taxpayer and the senior citizen some relief from such sharply escalating hospital bills."

Medicaid upgrades system to save $275 million.

Improving the system of verifying eligibility for the Medicaid program is expected to save about $275 million in Federal funds during fiscal year 1979.

The revised system will help stop such losses as those cited by HCFA Administrator Robert A. Derzon for fiscal year 1977:

- $1 billion from Federal and state payments made to ineligible patients.
- $600 million due to not collecting from medical insurance companies covering Medicaid beneficiaries.
- $200 million wasted due to claims processing errors.

Before Medicaid pays a bill, the new regulations will require the state to determine if other medical insur-

ance coverage is available to the Medicaid patient. States will also be required to review for errors in claims processing to make sure that payments to health care providers are based on complete and accurate claims.

Final regulations issued recently by the Health Care Financing Administration require states to implement the necessary changes in their review systems by November. Changes for collecting from companies insuring Medicaid beneficiaries and improved claims processing must be made by July 1.

Most state Medicaid agencies have begun planning for the required changes, and a phased implementation is allowed where necessary.

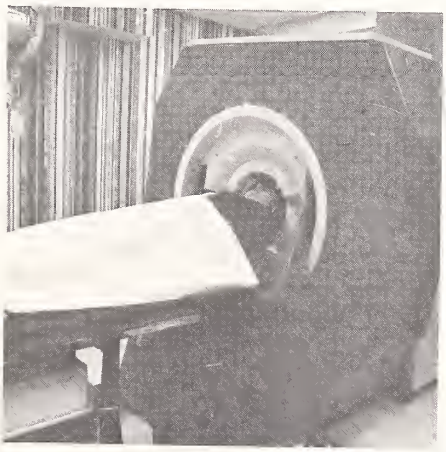
Pharmaceutical advisors named for HCFA.

Nine persons have been named to the Pharmaceutical Reimbursement Advisory Committee, which participates in setting of maximum allowable costs (MACs) paid for prescription drugs under the Medicare and Medicaid programs. The appointments bring the committee to its full 15-member complement.

Under the chairmanship of Dr. James Doluisio, dean of the College of Pharmacy of the University of Texas, Austin, the committee advises the Secretary and the HEW Pharmaceutical Reimbursement Board on MAC drug pricing.

The new members are: Victor Boisseree, pharmacist and chief of purchase plans for California's Medicaid agency; Morris Boynoff, pharmacist of Mendicino, California; Dr. Gloria B. Jackson, Chicago physician and specialist on drug abuse and family health care; Dr. Rosalyn Cain King, pharmacist and consultant based in Silver Spring Maryland; Dr. Leonard Schifrin, professor of economics at the College of William and Mary; Dr. Irene Till, economist and consultant on the drug industry, Arlington, Virginia; Fred Wegner, economist and drug legislation specialist for aging organizations, Washington, D.C.; Michael Zagorac, Jr., Belleaire, Florida, pharmacist and vice president of Jack Eckerd Corporation, drug chain; and Michael Bongiovanni, president of E.R. Squibb and Sons, Inc.

Continuing members of the committee are: Edward S. Albers, Jr., president and general manager of Albers Drug Company, Knoxville, Tennessee; Frederick M. Eckel, associate professor of hospital pharmacy at the University of North Carolina; Raymond A. Gosselin, president of Massachusetts College of Pharmacy; Alfred A. Mannino, corporate vice president of Marion Laboratories, Inc., Kansas City, Missouri; and Davis D. Thompson, M.D., director of the Medical Board of the New York Hospital.



CT scanners priced under certificate of need level.

Computer tomography scanners are now on the market at prices that allow hospitals in many states to buy them without certificates of need being required.

Manufactures cite a number of reasons for the lower cost. Some elements have been shown to be nonessential and they have been eliminated from newer modules, and more effective fabricating procedures have been developed. Competition has also played a significant role. When the first model was introduced in 1972, only one company was marketing CT scanners. Now at least 20 manufacturers are producing them. In addition, a market is said to be developing for reconditioned scanners.

Federal regulations require health facilities that participate in Government programs to demonstrate need and justify expenditures for equipment costing over $150,000, although some states have set a lower limit.

About 1,000 CT scanners are now in operation in the U.S., the majority in facilities with at least 500 beds.

State begins substitution of generic drugs.

Pharmacists and physicians in New York State have begun substituting generic drugs for equivalent brand-name products.

The State's list of drugs is part of a new program to reduce prescription drug costs without sacrificing quality. The FDA has called the drug list "an accurate guide to prescription drugs considered by FDA to be safe, effective and equivalent in therapeutic performance."

The Pharmacy Society of New York State sought an injunction against the substitution on the grounds that it interferes with using their professional judgment, but a Federal District Court allowed it to go into effect, while taking the case under advisement.

Under a recently passed state law, physicians may, after notifying the patient, instruct the pharmacist to fill a prescription with a less expensive product, provided it appears in the state's approved list of equivalent drugs. The pharmacist is then required to comply with the physician's instructions.

Continued on page 31

Dependent Adults Helped to Live in Community Settings.

Hundreds of elderly and mentally impaired persons who cannot live alone are avoiding institutional care through a Pennsylvania program that provides supplementary income and social services.

Persons placed in a certified home receive room, board, companionship and help with the daily routines of life, such as personal hygiene, dressing, taking medications and writing letters. Needy persons enrolled in the program receive $325 a month—$178 from the Federal supplemental security income program and $147 from the state. Of this, the enrollee keeps $50 a month for personal expenses.

Currently 513 persons are living in these homes for about nine dollars a day each instead of in a nursing home for $25 to $30 per day, or in other facilities that may lack the services they need. About 60 percent are 65 or older.

If a quarter of Pennsylvania's nursing home population could be placed in these homes, the savings would be about $100 million per year, says Dale K. Laninga, coordinator of the state's Domiciliary Care Program.

Each of the state's 322 certified homes must meet rigorous fire, safety, health and sanitation standards. "The most important service a domiciliary care home offers the resident is an understanding and encouraging family atmosphere that can make the difference between living and just existing," says Mr. Laninga. "Yet the individual retains control over his own life and activities."

Before the domiciliary care program began in 1976, Pennsylvania offered few options to those who could no longer live independently, but did not need institutional care. A few counties sponsored adult foster homes which offered a less intensive level of personal care than nursing homes, but, generally, these homes served only the elderly or persons discharged from state hospitals.

State officials were not ignoring the situation; indeed the concept of domiciliary care—community living, but with more intensive services—had been brewing for nearly a decade. In 1974, Secretary of Public Welfare Helene Wolgemuth and director of the state's Bureau of Aging Robert Benedict (now U.S. Commissioner on Aging) sought money to run such a program, but were unsuccessful.

The need for alternative care intensified after the movement in the early 1970s to take as many elderly, retarded, handicapped and mentally ill persons as possible out of large institutions and place them in community settings. But this was often done with insufficient preparation and support, and many persons ended up in boarding houses where their meager funds paid for room, board and services whose quality ranged from marginal to bad. Simultaneously, inflation caused the cost of nursing homes to skyrocket, putting them out of the reach of many.

The Domiciliary Care Program began in August 1976 after funds were authorized by the State Legislature for income supplements for needy enrollees. "Without this supplement, the program would not have gotten off the ground," says Mr. Laninga. Initially 28 persons were placed in a dozen homes. Some were homes that had provided facilities under a foster care program for the mentally retarded and were converted to domiciliary care.

Key to effectiveness

The program's success to date, according to Mr. Laninga, can be attributed to its triple focus on: assessment of applicants' needs, supplemental income assistance, and placement in approved and supervised homes. He points out that, in most other states, community care programs have concentrated primarily on either income assistance or social services.

Under an income assistance program the person typically receives enough money for living quarters and some personal care services. However, locating a home is the person's responsibility. On the other hand, programs stressing human services place the person in a supervised living arrangement with appropriate services. But he is responsible for the cost. As a result, resources are often exhausted, while the operators of the homes complain that payment is inadequate for what is provided.

Pennsylvania's Domiciliary Care Program was designed to avoid these problems. Enrollees are certified as to

A Typical County Program.

York County, which consists mainly of small towns and fertile farm country, operates neither the largest nor the smallest program in Pennsylvania.

The county has 20 certified domiciliary care homes which are divided between town and country, with several located on farms. Some of the homes converted, with their enrollees, to domiciliary care from mental health foster homes and programs connected with the county home for the elderly.

Presently financed with $86,000 a year from Federal and state Title XX social services funds, the program is mandated to place 150 clients in 50 approved homes by the end of 1978. The program has a county coordinator and four caseworkers.

"Matching the right clients with the right homes is our key to effectiveness," says Program Coordinator Jim Knisley, who is a registered psychiatric nurse and a long-time resident of York.

After screening an applicant, a home is selected and a staff member accompanies him to the home for a visit. Preference in such matters as smoking, children and pets are explored by all parties. If that goes well, the applicant returns for an overnight visit.

Denial of an applicant is rare, although several suffering from organic brain syndrome, which can cause impaired judgment, have been turned down and referred instead to nursing homes.

One success story Mr. Knisley likes to tell is about an 85-year-old woman who, after being independent all her life, went into a psychotic state and had to be hospitalized after she found she was unable to shop for groceries, cook meals properly or pay her bills. Staff members visited her on the psychiatric ward and arranged for her to be placed with a congenial family. Surrounded with an "extended family" of husband, wife, three youngsters and an elderly grandfather, and relieved of stress, she has recovered all her faculties. Without domiciliary care, she probably would have been permanently institutionalized.

The certification process of a domiciliary care home begins with a check of the owner's personal and financial references, and concludes with the signing of an agreement. Although the operator of the home is expected to drive residents to medical appointments, other transportation services are available. To insure standards are maintained, homes are inspected quarterly. In addition, caseworkers visit residents monthly. The caseworker fills out a form for each visit, including how the $50 pocket money was used, so there is no forgetting, misunderstanding or misuse.

The owners of the homes attend monthly meetings for training, in such subjects as the aging process and recreation for the mentally impaired.

"There is excellent cooperation from community agencies," says Mr. Knisley. The Area Agency on Aging provides various services, such as counseling and therapy for mental health patients, and there is a sheltered workshop for the mentally retarded. We've had a few crises, including a stroke and several 'walk-aways' but the local psychiatric emergency service has helped with those.

"The mental health association sponsors picnics and parties to which all our clients are invited.

"From my experience in foster home administration, what makes this program superior is the degree of supervision of both the homes and the beneficiaries. The supervision is close and residents have a much better quality of living than they would otherwise. They are in the mainstream of life, not in a warehouse or back room." ■

both income and need; homes are approved only if they can provide the room, board and supportive services required. The applicants' needs are matched with homes before placement. Through frequent monitoring, the placement agency makes sure that the resident continues to need care and that the home continues to provide it.

Assessing applicants

Careful assessment of the needs and problems of the person seeking care is necessary to insure he is placed in the most appropriate living situation, whether it is a domiciliary care residence, an institution or a home with social and health services.

To be eligible for the program, adults must: (1) have demonstrated, over an extended period of time, marginal social adjustment which prevents independent living in the community; (2) not require intermediate care, skilled nursing care or hospital care on a 24-hour basis; (3) have no family or friends who can provide necessary support; and (4) lack sufficient in-home services for independent living.

A person is considered to be marginally socially adjusted when he has problems with such daily activities as purchasing food, fixing meals, housekeeping, laundry, taking medication properly, personal grooming and handling financial matters. Those with a mental disability may have marked difficulties in social or personal adjustment, such as an inability to develop or maintain appropriate relationships with others, deal constructively with others or make decisions necessary to achieve a basic level of functioning.

"In assessing a person, we consider his total situation," says Mr. Laninga, "as none of these characteristics can be considered alone. A staff member completes a 20-item assessment form which is then evaluated. We look for factors that form a pattern of behavior, not just those that are occasional occurrences such as any of us might experience."

Adults handicapped by blindness, deafness, amputation, paralysis or birth defects may be candidates for

domiciliary care, provided they are independently mobile and "capable of self-preservation." Some persons, otherwise capable, may need help with special diets or supervision of their medication, yet not require constant nursing or medical care.

"Incidentally, it is our policy not to break up a family unit when placing a person. For example, in a few cases where a husband or wife only has needed care, we have arranged for the spouse to stay in the same domiciliary care home on a private-payment basis. The same is true of a mother with a dependent child."

For a lasting and effective placement, there must be a precise match between the home and the prospective resident. After a comparison on paper, a staff member from the local office always arranges at least one visit to the home for the enrollee to be sure he likes it and vice versa. This is often followed by an overnight visit. The decision to move to a domiciliary home is made entirely by the prospective resident, and he may reject the home for any reason—neighborhood, economic level or even ethnic factors.

"We try to help the applicant find a home where there will be mutual interests—for example, crafts, gardening and other hobbies. We consider, as far as possible, wishes as well as needs."

Of the 2,399 persons applying to enter the program since it began,

Dependent Adult Program*

Living situation at time of referral	Source of Referral: Elderly Program	Mental Health Program	Mentally Retarded Program	Other **	Total
Persons referred to program:	1,020	526	465	207	2,218
From community	834	275	363	175	1,647
Living at home or in nursing home	720	260	169	165	1,314
Converted from existing foster home or other agency sponsored living program	114	15	194	10	333
From institution	186	251	102	32	571
Disposition of Referrals					
Persons denied certification	463	221	151	77	912
Persons certified	394	233	282	68	977
Persons placed in domiciliary care home	255	117	201	46	619
Persons terminated after placement	70	20	21	7	118
Persons currently placed	—	—	—	—	513
Persons awaiting placement	—	—	—	—	124

*Cumulative figures since program started, July 1976. **County Boards of Assistance, relatives, hospitals, physically handicapped programs, etc

Home Certification

Applications received	990
Homes inspected	768
Applications denied	167
Homes certified	452
Applications awaiting action	149
Homes withdrawn from program	74
Certification cancelled	11
Homes Currently in Operation	332

about 45 percent have met the requirements for admission (see chart). Generally, those denied needed either a higher level of care than the homes provide or did not need as much. Some 63 percent of certified applicants have been placed; the remainder are awaiting placement.

Financial qualifications

Income supplement for the participants is a major key to the program's success, according to Mr. Laninga. Most (about 95 percent) of the persons presently enrolled qualify for the supplemental payment ($147.30 per month), because their incomes are less than $315 per month. The supplement enables the financially needy aged, blind and disabled to take part in the program.

"Guaranteeing $50 a month pocket money as our program does, gives the client a feeling of independence and self worth," says Laninga, "Quite a few boarding homes outside our program take their residents' entire supplemental security income checks for room and board, leaving them absolutely no money for other needs and incidentals."

To qualify for the state's supplemental payment, a person must first be eligible for the Federal-state Supplemental Security Income Program.* Payment begins when the person enters a certified home. Should he leave and not enter another certified home the state domiciliary care supplement stops, although his eligibility for the Federal supplement is not affected.

Home certification

A typical domiciliary care residence is a private home in a residential area occupied by one or two adults. Not infrequently, the operator of the home is a widow who has not given up her large home after her husband's death. Some 60 percent of the operators are elderly, and the next largest group consists of couples under 30. One person is responsible for operating the home, with a second person designated to act in his absence.

At present, most homes certified by the program accommodate one to three persons. Program rules permit up to 13 in a home, but those facilities with four or more persons must meet more stringent standards.

Before a home is certified under the program, it must meet detailed requirements. These relate to such matters as water supply, sewers, heating, size of bedroom, window area, storage space, compliance with fire and safety regulations, furnishings, equipment, linens, repairs and exits.

The operator of a home must also ensure that each resident has clean and proper clothing for all weather, a bathrobe, shoes, slippers, stockings, underclothing and toilet articles. At least three well-balanced meals are required daily, the first served between 7 and 9 a.m., and the others about five hours apart, with no more than 14 hours between the evening meal and next day's breakfast. Any medically prescribed dietary restrictions must be observed. Wholesome food is to be served in a dining room or dining area (not a bedroom, except in case of illness). Clean and appropriate dining chairs, tables, dishes, equipment and utensils are required.

Those operating the homes are also expected to offer a supportive social environment, assist residents with personal care tasks and help them develop or maintain self-help skills.

"After all, one objective of domiciliary care is to help clients achieve maximum independence," says Mr. Laninga. "Since the program began, 118 persons or about 20 percent of those placed have left it. Some improve to a point where they need less care and supervision, and may return to independent living. Of course, there are others whose conditions deteriorate despite good care. When this happens we help place them in a nursing home, hospital or other appropriate facility."

The program is also responsible for seeing that appropriate community services are provided each enrollee, such as medical care, therapy, recreation and transportation. Generally, the services are provided at no charge to the individual through arrangement with other community agencies.

"The $275 per month we pay certified homes is well above the average charged by most boarding houses and foster care homes, so it is a great incentive for people to seek certification. Of course, without the supplemental payment from the state, this incentive would not exist." The other approach to placement is where a state heavily regulates boarding houses and similar facilities without providing funds to upgrade them; this simply reduces the number of persons who will seek certification. Regulation is good, but alone it isn't the entire answer to the problem.

Finding homes that meet all the standards and homemakers who will provide good care has been one of the most challenging tasks of the program. To do this local staffs work with community leaders and groups to recruit individuals and families who might not otherwise consider offering their homes. Newspaper, television and radio publicity about the program also brings in candidates. In one case, an advertising firm was persuaded to prepare a recruiting TV commercial without charge. A 30-second announcement boosting domiciliary care by the state's lieutenant governor has proved to be an effective recruiting tool.

Some 74 homes have dropped out of the program, while certification was withdrawn from 11. Usually, termination occurs because the home no longer meets standards, although occasionally it is the preference of the provider.

Administering the program

Coordination is the key to Pennsylvania's domiciliary care program. Recognizing that many groups—from the infirm elderly to the physically handicapped—can benefit from such services, the Department of Public Welfare drew funds from the state's aging, mental health, mental retardation, income maintenance and visually handicapped programs to set up domiciliary care. The chief executive of the program is the Commissioner on Aging, who has an advisory committee consisting of members from the various programs.

*Supplemental Security Income is available to all persons who are 65 or older, blind or disabled, and whose income and resources fall below a federally established minimum.

In each region of Pennsylvania where the program is operational, an advisory committee works with the domiciliary care coordinator to make sure that concerns of all groups are addressed. The committee also offers technical expertise for each category of enrollee. In each of the four regions of the state, there is a domiciliary care coordinator, who is a member of the Department of Public Welfare regional staff.

The same agencies are represented on the local review team that advises the placement agency staff. The local Area Agency on Aging, upon approval by the Department of Public Welfare, serves as the placement agency. The domiciliary care staff assesses and places persons, inspects homes initially, assesses them periodically, and regularly visits residents who have been placed to insure that all is satisfactory.

As no specific funds are allocated to administer the domiciliary care program or to provide services, monies have had to come from myriad sources—Federal, state and local. Funds for social services, under Title XX of the Social Security Act, and for elderly programs, under Title III of the Older Americans Act, have been used, as well as state and county funds, voted by county commissioners.

Program to expand

HEW has funded a study to evaluate the effectiveness of the program. Some of the questions the study is expected to answer are:

How well does the program attract foster and boarding homes and increase the number of improved personal care facilities? What is the impact of a domiciliary care home on its residents? Where would this person have gone if the home were not available? How effective is the program's screening, assessment and placement of applicants?

By the end of 1978, Mr. Laninga expects to have 1,000 domiciliary care homes in operation in the program's 10 areas.

Plans call for expanding the program statewide if additional funds, either from state or Federal sources, can be obtained. ■

Can Health Insurance be Competitive?

by Dr. Warren Greenberg

Most economists have suggested that increased insurance coverage has contributed substantially to escalating costs in the health care industry. Insurance coverage in other industries, however, has not necessarily led to substantial increase in the cost of the product.

In the automobile repair industry, for example, insurers control the cost of claims by requiring multiple estimates or by inspecting damage prior to repair. Workman's compensation insurers conduct safety inspections and use experience-rated premiums to encourage accident prevention.

And, in dental insurance, akin in many economic and sociological respects to traditional health insurance, there is active intervention by insurers in the dentist-patient relationship in order to control costs.

A number of explanations have been advanced as to why health insurance firms have not been more active in controlling costs. They include the existence of physician-controlled health insurance, the tax laws which favor shallow coverage, the threat of boycott by providers and the nature of the physician-patient relationship. There is still another possible explanation for the lack of cost control—the current unconcentrated structure of the health insurance industry.

It is the contention of the Health Insurance Association of America that insurers "have been unable to accomplish as much in the way of genuine cost containment as they could because of their inability to negotiate jointly with health care providers."

Health insurance industry

The private health insurance industry consists of the non-profit Blue Cross and Blue Shield plans and the for-profit insurers. The 74 Blue Cross plans, originally created by hospitals, and the 71 Blue Shield plans, originally created by physicians, are located in most of the 50 states. In 1976, Blue Cross, Blue Shield and other hospital-medical organizations had 50.1 percent of the total hospital-medical market.

About 1,000 for-profit insurers throughout the United States cover hospital and physician expenses. According to HIAA, no one firm has more than 3.6 percent of the entire health insurance market, while the top 10 and the top 20 firms have less than 22 and 28 percent of the market respectively. This does not preclude the possibility, however, that certain firms may have larger shares of local markets.

What is the behavior of the for-profit insurers in terms of effecting cost control?

It is implicit in economic analyses which discuss increased insurance and rising health care costs that insurance firms do not address themselves to cost control. In contrast, in a February 1977 survey conducted by HIAA, a number of findings suggests that health insurers do attempt to control costs. Of the 30 largest for-profit

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Dr. Warren Greenberg is an economist with the Federal Trade Commission's Bureau of Economics. This article is adapted from a paper presented at an American Enterprise Institute conference in Washington in December and is printed with permission. The views expressed in the article are not intended to be, and should not be construed as representative of the views of any other member of the FTC staff or the Commissioners.

group health insurance carriers, a majority of the firms attempt cost controls by:

- Covering the cost of outpatient pre-admission testing for elective surgery.
- Covering the cost of second or third opinion for elective surgery.
- Covering some types of preventive care, including well-baby care.
- Promoting increased consumer awareness of deductibles.
- Using organized peer review committees to settle disputed claims.
- Using the HIAA prevailing charges program to monitor fees.

Although it may be acknowledged that health insurers are attempting to control costs, the question of whether they have been successful remains an open one. For example, there is no claim from the insurance industry that insurers question physician practices in ordering tests, admitting patients or determining lengths-of-stay. In contrast, in the dental industry there appears to be a direct effort by insurance firms to control costs.

Competition in dentistry

Dental insurance has grown enormously in the past decade. In 1965, only 2,000,000 people were enrolled in prepaid dental plans offered by fewer than 100 employers. By 1976, however, 30 million people had dental coverage with more than 11,000 employers. Dental insurance plans vary, as do health insurance plans, but may include benefits as extensive as the United Automobile Workers contract with the Aetna Life and Casualty Company wherein diagnostic and preventive services, general services and prosthodontics are included.

Similar to the health insurance industry, the share of the market controlled by the largest for-profit dental insurers is relatively small. Of the 30 million beneficiaries in dental care plans in 1976, the for-profit insurance firms enrolled 18 million or 58 percent. The largest four for-profit carriers, Metropolitan Life Insurance Company, Aetna, Prudential Insurance Company of America, and Connecticut General Life Insurance Company, had only 7.8 percent, 6.6 percent, 5.3 percent and 5.0 percent respectively of dental beneficiaries at the end of 1975. And, although there are fewer for-profit firms than in health insurance, the American Dental Association reports that there are more than 170 carriers.

It is reasonable to conclude that the for-profit segment of the dental insurance industry can be classified, like the health insurance industry, as unconcentrated by any measure.

How do dental insurance firms affect cost control?

In many group dental plans, insurers review claims in two stages. In the first stage, the insurance carrier reviews a proposed treatment, which is expected to cost in excess of a certain dollar value, for its necessity and appropriateness. This review attempts to eliminate misunderstandings among the patient, the dentist and the insurance firm before work is performed. Second, dental consultants on the insurer's staff suggest alternatives to the treatment proposed by the dentist, if necessary.

Under its United Automobile Worker's contract, the largest prepaid dental contract in the United States, Aetna, for example, questions not only whether various procedures are covered but also "claims where the charges are for services and supplies which appear not to be necessary for treatment, or where the charges appear to be above the prevailing charge level." In addition, Aetna's investigation of questionable claims might include:

- Discussion of the treatment with the dentist.
- Examination of dental x-rays, study models, etc.
- Review of cases by professionals.
- Examination of the patient.
- Referral to the local dental society review committee.

Unlike health insurers, dental insurers seem willing to question professional practices. Under competition, dental insurers have incentives to control costs to insure that their premiums are competitive with other firms in the market.

The unconcentrated dental insurance market does not appear to be a deterrent to Aetna's behavior. It is doubtful, since Aetna monitors not only the services which are covered but also the professional's procedures and fees, that the company could be more comprehensive in its surveillance if the industry were more concentrated.

Is it possible that health insurers, with many of the same incentives as dental insurers, might be more aggressive if the industry were more concentrated?

One might argue that regardless of the structural configuration, health insurers might not be able to perform like dental insurers. Although all insurers have similar incentives to maximize profits, and both dental and medical insurance include involvement with professionals, greater uncertainty of outcome, greater risk of certain procedures, greater ignorance of the consumer about medical procedures, and more emergency or quasi-emergency treatments, may force health insurers to behave differently in degree than dental insurers.

However, if dental insurers can vigorously control costs in an unconcentrated market, surely a lesser degree of vigilance by health insurers should not be hampered by the unconcentrated health insurance industry.

Possible cost controls

One might suggest a number of methods for insurance firms to control costs if granted an antitrust amendment encouraging cooperation. Firms might attempt to secure a discount on charges from hospitals, such as the discount Blue Cross receives in most sections of the country.

If health insurers were to receive a discount similar to the one received by Blue Cross, however, this would not lower costs for all those insured, since there would be no reduction in real resources used. It would involve an equivalent amount paid to hospitals by health insurers and Blue Cross, and an income transfer from those insured by Blue Cross to those insured commercially. Firms might cooperate in the collection and publication of data on fees and procedures, to attempt a more aggressive negotiating stance, but the dental experience suggests that firms need not combine to do this.*

* Professor Mark Pauly of Northwestern University has suggested to me that a single

It is possible that greater efforts might be made to review the construction or expansion of hospitals, but there are certificate-of-need laws and health systems agencies with this objective.

On the other hand, what incentive might a combination of firms have to control costs if competition among them were to be removed? How would a combination of firms affect the entry of new firms? What relationship would the insurers have with Blue Cross? What would be the response of physicians and hospitals? Would combinations of physician groups and hospital groups emerge as in Western Europe? Would a bilateral monopoly price for physician and hospital services result?

Empirical evidence for these questions is lacking. There is wide variation in the market shares of Blue Cross plans across the United States, however, and a cross-section examination of the effects of Blue Cross plans might shed some light on the health insurance industry.**

The Blue Cross plan market share of the total persons insured for hospital expenses ranges from 21.0 percent in Arizona to 82.0 percent in Rhode Island. One can hypothesize, given the expectations of the proposed HIAA amendment, which would allow insurance firms to jointly negotiate with providers, that the greater the Blue Cross market share, the more effective the cost control. Therefore, in a statistical analysis, one could test, using Blue Cross market shares as a proxy, what the effect of different insurer market shares may have on cost containment.

A statistical analysis tested the effect of the share of the market of Blue Cross on hospital use and maternity length-of-stay rates of Blue Cross members, holding a number of variables constant.† In the first equation, in a cross-section analysis of the United States in 1974, hospital utilization rates by Federal Government enrollees with Blue Cross high-option coverage, were regressed on the Blue Cross market share, income per capita, physician-population ratio, bed-population ratio and the average temperature.

Since all Federal employees have the same benefit package, variation in utilization due to extent of coverage was controlled in this analysis. A positive, but nonsignificant, relationship was found between the Blue Cross market share and hospital utilization rates.

In the second equation, maternity length-of-stay for Federal employees was used in lieu of hospital utilization rates in an attempt to control for age, sex, weather and reason for hospitalization. The Blue Cross market share, per capita income, and the bed-population ratio were the independent variables.

These results, in contrast to the first equation, showed a significant, positive relationship between Blue Cross market share and maternity-length-of-stay, indicating that the lower the Blue Cross market share, the shorter the length-of-stay for maternity patients.

These results suggest that the Blue Cross plans with comparatively lower market shares may engage in greater control of hospital utilization.†† In contrast, in the high Blue Cross market share areas, Blue Cross may not have the incentives to effect utilization review. (Although, in general, I would agree with the proposition that firms, regardless of monopoly power, have incentives for cost control, it may not be applicable here since controlling costs imposes costs on the insurer as described above. With a dominant, and perhaps insulated position, Blue Cross may elect not to incur these costs.)

The foregoing analysis, although a beginning, cannot provide the definitive answer as to the best configuration of the health insurance industry for cost control. The topic is much too complex.

However, in the dental insurance industry, firms were able to control costs to a degree even with relatively low market shares, and, in the health insurance industry, evidence indicates that Blue Cross was more successful in controlling maternity length-of-stay in states where their market shares were lower. Nevertheless, a complete understanding of the differences, if any, between dental and health insurance, and additional empirical work using health insurance rather than Blue Cross data, ought to be attempted. Furthermore, a model of insurer behavior, taking into consideration the employer, the consumer, and the providers, should help shed more light on these important issues. ■

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health insurer may be reluctant to engage in cost control efforts since other insurers will be able to reap the benefits of lower costs without expending their efforts to contain costs (the economist's free rider principle). I agree that there are internal costs to insurers in their cost control efforts. These costs may include the risk of alienating the providers and patients, the threat of boycott by the providers, and the transactions costs in monitoring the practices of physicians and hospitals. However, it is not clear that the benefits from cost control will always accrue to other insurance firms. For example, if one firm institutes a paid second opinion for elective surgery, any benefits need not accrue to another firm. Another example is the use of deductibles and coinsurance in insurance plans where benefits accrue to the insuring firm only.

When one analyzes not a single physician and his procedures, but hospitals which procure equipment used by many physicians, Pauly's point may be well taken. However, to the extent that physician's use of tests and procedures are examined, the pressures on hospital procurement may be modified.

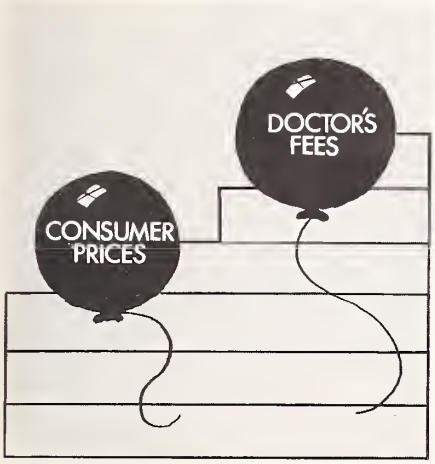
** A cautionary note is in order. Blue Cross plans may have incentives different than private insurers because of the non-profit nature of the plans and their attachment to hospitals. However, the most commonly expressed incentive, that of maximizing the number of its subscribers, makes little or no difference in this analysis. Blue Cross still has incentives to control costs in order that their premiums be competitive. Furthermore, Blue Cross attachment to hospitals appears to have diminished.

† Hospital utilization rates, or patient days in hospital per 1,000 enrollees, are not, of course, the same as costs. However, if utilization is controlled, in the long run costs are bound to be affected.

†† Frech and Ginsburg recently found a significant positive relationship between the Blue Cross market share and the price of hospital care (a weighted average of charges for semi-private rooms), using 1969 state data. This result appears to be consistent with the contention that high market shares reduce incentives for cost control. See H.E. Frech III and Paul B. Ginsburg, "Competition Among Health Insurers" in U.S. Federal Trade Commission, Bureau of Economics, *Competition in the Health Care Sector: Past, Present, and Future: Conference Proceedings*, forthcoming (edited by Warren Greenberg).

State and National News

Continued from page 21



Study says physician fees rising at disturbing rate.

Costs of physicians' services are increasing at a disturbing rate—1½ times as fast as other consumer prices, according to a study issued recently by the Council on Wage and Price Stability.

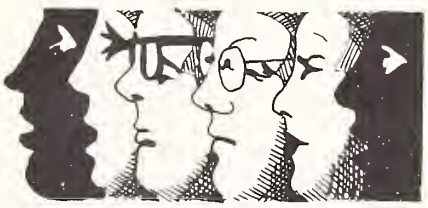
Last year, physician fees rose 9.3 percent, following a pattern spanning nearly three decades, the council reported. Between 1950 and 1977 fees increased 43 percent faster per year than non-medical prices. The increased cost to the consumer is even greater, encompassing not only the higher fees, but also population growth and increased physician services. This represents a dollar increase of from $2.7 billion in 1950 to about $35 billion in fiscal year 1978. Of this increase, 60 percent resulted from higher fees, with the remainder caused by population growth and an increase in the quantity of physician services, such as diagnostic tests and more frequent visits.

The study shows that the median income of self-employed physicians—$63,000 in 1976—is higher and has risen faster than that of any other major group for which income data are available. Among broad speciality groups, pathologists and radiologists had the highest annual earnings, estimated at about $100,000 in 1975.

One frequent explanation for high physician income is that it is necessary to attract an adequate supply of applicants in the profession. However, rates of return on investment in medical training far exceed rates of return for training in other fields, the study concludes.

The rapid growth in physicians' fees and consumer outlays for their services is said to be attributed to several causes: anticompetitive practices of organized medicine prior to 1965 (which will not, however, be a contributing cause of physician fee inflation in the future); recent payment practices by medical insurance companies that result in the physician virtually determining his own fee; and dramatic improvement in the medical care system combined with the willingness of the American people, with higher incomes and better insurance coverage, to pay for it.

The supply of physicians continues to rise, and the study notes evidence that a substantial proportion of new physicians are practicing in already oversupplied areas, possibly inducing demand for their services and raising their fees. Thus, additional physician and hospital costs may be generated in these areas, with little improvement in overall health care.



Dr. M. Keith Weikel, former director of HCFA's Medicaid Bureau, has been named corporate vice president of American Medical International, Inc. of Beverly Hills. He will be headquartered in Washington.

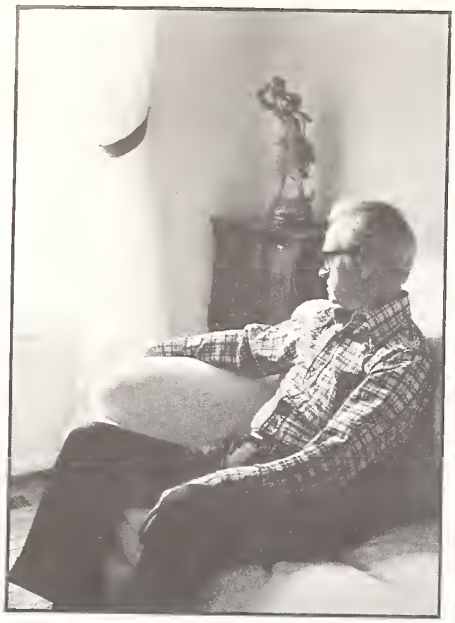
Thomas M. Tierney, who has headed the Medicare program since its early years, has announced he will step down as director of HCFA's Medicare Bureau to become a regional commissioner of the Social Security Administration. He will be based in San Francisco.

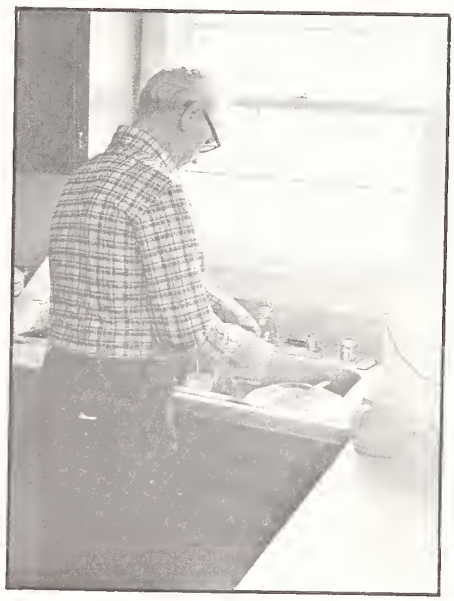
Few new medicines found superior to old ones.

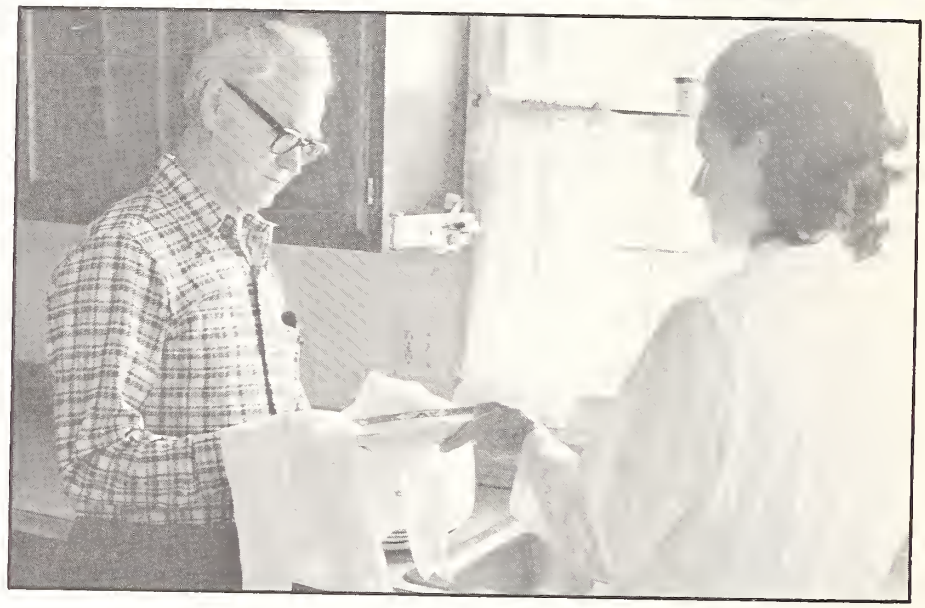
Only 6.4 percent of new prescription medicines approved by the Food and Drug Administration during a two-year period offer "important therapeutic gain" over existing products, while 15 percent offer moderate therapeutic gain and 79 percent show no advance.

These findings were reported by FDA's Bureau of Drugs, which evaluated 170 medicines that the agency approved for sale between October 1975 and January 1978.

Under current laws, a new medicine need not be better than or even as good as drugs already on the market to receive approval. Companies often market established drugs under new names or develop their own version of another company's drug. In such cases there are no therapeutic advances. In any event, the medicine must only live up to claims made about it and be safe and effective.







Nursing Home Costs Halved by Home Maintenance Program

by Ruth Shepherd

A new program of home and community services in Oregon is helping some 5,000 poor elderly residents stay in their own homes. The average monthly cost per person is about $120 compared with about $255 per month for a nursing home bed.*

The typical Project Independence client is white, female, aged 75 years, widowed, and has less than $3,000 annual income from private sources and social security. She lives in her own home, probably has been recently hospitalized, and has problems of circulation, arthritis and respiratory disorders. She is partially or totally housebound. Monthly services for the typical client average: 23 hours of homemaking services, 2.5 hours of home health services, 13 free rides, 10 home delivered meals and one hour of counseling.

Among the other services offered are: telephone reassurance (someone regularly telephoning the enrollee to be sure all is well), "friendly visiting," counseling, chore service, home health care, home-delivered meals and transportation. Some 90 percent of the total statewide services are delivered to enrollees in their own homes.

Free service is provided a person in a high risk category whose individual income is $3,000 or less per year ($5,000 if living as part of a couple). Eligible persons whose incomes are above those levels pay according to their ability.

The major criteria for admission to the program is that the person must be 60 years of age and in great risk of being placed in an institution within a year. Project Independence workers use an intake form designed to help them assess the needs of the individual and rate the risk of institutionalization for each applicant. (See accompanying form.)

Risk factors include: difficulty with shopping, working, housecleaning and transportation; disabling health problems; limited mobility; problems with vision, hearing or teeth; need for medical care or hospitalization; loss of spouse or relatives; housing problems; and financial difficulties.

If the number of risk points totals 35 or more, the applicant is eligible for the program. In the winter of 1977, the average number of points for enrollees in the program was 72, with 67 percent scoring over 60. Early in the operation, 97 percent of the enrollees were judged by an independent evaluator to be at very high risk of needing institutional care without Project Independence services.

Services provided

Many of the more populated areas had some capacity to serve the new enrollees, but rural areas varied in their ability to respond, with some offering virtually no services. As a result, and with approval of the Governor's Commission on Aging, the Office of Elderly Affairs set aside about one-third of the initial funding for start-up efforts in districts that needed to, say, establish a bus route or put together a homemaker service.

Throughout the program, homemaking has been the most commonly needed service, but one for which there were relatively few sources in rural areas. Now, a number of new private and non-profit organizations have developed.

Services have been given standard definitions and are provided by local service provider agencies under contract with local Area Agencies on Aging.

Evolution of the program

A search for alternatives to nursing home care began to take shape in 1971 stimulated by ideas gained by Oregon's delegates to the White House Conference on Aging that year and by the relatively new Older Americans Act. Elderly activists from the Governor's Commission on Aging and the Oregon State Council of Senior Advocates prodded state legislators, administrators, and local officials to accelerate action to help elderly persons remain in their own homes.

Governor Bob Straub joined the advocates on his election in 1975, and developed and implemented a two-year program of "supportive social services for persons aged 60 or older." That launched Project Independence.

Oregon's Project Independence was begun in 1975 because state officials and legislators became aware that:

- There were very few options available to elderly persons who had difficulty managing at home other than entering nursing homes.
- Public dollars were more readily available for nursing home care of low-income persons than for alternative care. As a result, at least 15 percent of Oregon's nursing home population did not need medical care on the day of admission.
- Many low income persons become dependent on public funds (welfare) when admitted to a nursing home—or soon after.
- Most elderly persons and particularly those who really don't need nursing home care prefer to remain in their own homes.
- Services provided at home can often be effective—and less expensive—than nursing home costs.

Too often, when a decision is made for an elderly person to leave home for institutional care, it is only because a woman's stiffened shoulder joints make it hard for her to fasten her dress in back and reach her cupboard, or an otherwise healthy man experiences sudden and deep feelings of loneliness and despair upon being widowed.

A total of $929,000 was appropriated for the Department of Human Resources for program operations from July 1975 through June 1977. The department sought recommendations for program objectives from the Governor's Commission on Aging

*In 1977, state and Federal funds together provided about $255 for support of a nursing home bed, of which Oregon paid $180.

Ruth Shepherd is assistant administrator of Oregon's Office of Elderly Affairs and coordinator of the Governor's Commission on Aging. From 1973 to 1975, she was an administrative assistant and consultant to the state's House Committee on Aging.

Risk Assessment

Points

Problems
Difficulty with/or in need of
1 Yes
2. No

- Cooking 10 pts.
- Light Housekeeping
- Chore/Heavy Housecleaning
- Home Repair
- Basic Marketing 5pts.
- Shopping
- In Home Care 10 pts.
- Instruction
- Transportation 5 pts.

Health
Current Condition
1 Severe
2. Moderate
3. Mild

Each Severe 5 pts.
Each Moderate 2 pts

- Circulatory
- Respiratory
- Digestive
- Diabetes
- Arthritis
- Stroke
- Cancer
- Malnutrition
- Emotional Stress
- Other

Mobility
1. Good (Score One Only)
2. Partial ---------- 5 pts.
3. Housebound ---------- 10 pts.
4. Bedfast ---------- 10 pts.

Wheelchair 1. Yes 2. No

Vision
1 Adequate
2. Partial ---------- 3 pts.
3. Blind ---------- 5 pts.

Glasses 1. Has, wears 2. Has, does not wear 3. Has no glasses

Hearing
1. Adequate
2. Partial ---------- 3 pts.
3 Deaf ---------- 5 pts.

Hearing Aid 1. Has, wears 2. Has, does not wear 3. Has no aid

Teeth 1. Adequate 2. Inadequate

Hospitalized (Within Last Year) 10 pts. 1. Yes 2. No

Currently Seeing Doctor 1. Yes 2. No

Needs Medical Care 1. Yes 2. No

Current Social Condition (Within Last Year)
1. Yes
2. No

- Loss of Spouse
- Loss of Relatives/Friends
- Needs more Social Contact 5 pts.

Housing Status 1. Owned 2. Rented 3. Other

Condition 1. Adequate 2. Inadequate 5 pts.

Type Dwelling 1. Single Family 2. Duplex 3. Apartment 4. Mobile Home 5. Group Quarters

Protective Legal Services 1. Yes 2. No

Economic Conditions Benefits
1. Yes
2. No

- Social Security
- Medicare
- Pension
- VA
- Public Assistance
- SSI
- Food Stamps
- Medicaid
- Other

Financial Difficulty 5 pts. 1. Yes 2. No

Estimated Monthly Income

Estimated Yearly Income

Adjusted Income

Wants to
1. Yes
2. No

- Work
- Volunteer

Total "At Risk" Points

and delegated administrative responsibility to the Office of Elderly Affairs.

Project Independence monies are allocated to all areas of the state and managed at the local level by Area Agencies on Aging. The local AAAs write contracts with local provider agencies.

Typical enrollees

Of the current enrollees, about 70 percent are women, 58 percent live alone, 56 percent are widowed and 67 percent are 75 or older. Some typical Project Independence enrollees are:

- A partially paralyzed man, who is hard of hearing, has few teeth and lives alone in an isolated area. He can drive, but seldom sees his neighbors. "I've been in a nursing home," he says, "but you get so you hate it and everyone around you." Project Independence keeps him independent with personal care from a homemaker service and occasional help in cleaning his home.
- An elderly widow, who is nearly blind and must walk with a cane, has no family. She lives in a small, neat, second-floor apartment and can do her own cooking and housework. Project Independence arranged for a volunteer from the senior center to telephone her regularly and to provide transportation to help with shopping.
- A woman of nearly 90, somewhat confused and with only peripheral vision, lives in an apartment whose cluttered state distressed her landlord. Now she gets help with shopping and goes to the local nutrition site for lunch. Under project funding a housekeeper helps clean her apartment and a protective service worker visits regularly to assist in financial and legal matters, and other needs.

Day care

When Project Independence started in 1975, Oregon had no day care programs for the elderly, so two small day care demonstration programs were funded under the project.

Both day care centers are in the Portland area and feature a pleasant home-like atmosphere. Some patients have been recently discharged from hospitals and are referred for short-term therapy; others are isolated, lonely, frail persons who need to socialize and be assured of at least one nutritious meal per day.

Services emphasize social activities, crafts and games, and the hot noon meal, but include some nursing services as well as occupational and physical therapy. The centers are open weekdays from 7:30 a.m. to 5:30 p.m.

Transportation to and from the centers is arranged through a variety of local agencies and volunteer services for the elderly. Generally, the participants fall into one of three categories:

- Those who live with younger families that for one reason or another can no longer take care of them 24 hours a day. (Perhaps the wife has taken a job outside the home.)
- Those living alone have been isolated so long they need stimulation from an outside source.
- Those discharged from hospitals who physicians refer for occupational or physical therapy. (One such woman who had a stroke that affected her right side had difficulty in preparing meals. At a day care center, she learned to cook with her left hand.)

The two centers have aroused considerable interest and inspired some efforts statewide toward establishing further day care services. Area Agencies on Aging in several parts of the state are currently considering day care in their planning for 1978-79.

Administrative costs low

When Project Independence began, the legislature required that all funds be spent on services rather than administrative costs for the first 18 months. Thus, the program was "piggy-backed" on the existing management structure of the Area Agencies on Aging throughout the state, which are largely federally supported. Governor Straub credits these agencies for their concentrated efforts to establish Project Independence services during the initial two years of the project. The program's early successes must be attributed in large part to the continuous cooperation of the Area Agency staffs.

At this time, Project Independence enrollees and fiscal reports are submitted separately from records which report services rendered under the Older Americans Act. The Area Agencies are responsible for management of contracts written with local providers of Project Independence services.

Project Independence receives no Federal dollars. (Oregon long since reached its Federal ceiling for social services under Title XX of the Social Security Act.)

Other factors in keeping costs low are: (1) extensive use of employees paid by the Federal Comprehensive Employment and Training Act to provide services, such as homemaking; and (2) some 40 percent of services are relatively low in cost or performed by volunteers, such as telephone assurance, transportation and friendly visiting.

For the current two-year period (July 1977-June 1979), the legislature approved the department's recommendation to allocate five percent of the total funds for administrative costs. Two percent are assigned to the state-level Office of Elderly Affairs, with three percent to the Area Agencies on Aging. Even with added administrative costs, it is expected that expenditures will be below the $180 per enrollee that is the state's share of a welfare nursing home bed.

Improving the program

The program has received national attention through a seven-minute segment that appeared on an NBC network news program in June 1977. The camera crew (with permission of enrollees) went into enrollees' homes to illustrate how program services helped them remain independent. This stimulated inquiries from all parts of the country and even from England.

Now, very few parts of the state offer the full range of alternative services necessary to give the frail elderly all options that are needed for individual appropriate care. The Office of Elderly Affairs and Area Agencies on Aging are continuing an effort to plan and develop those additional options.

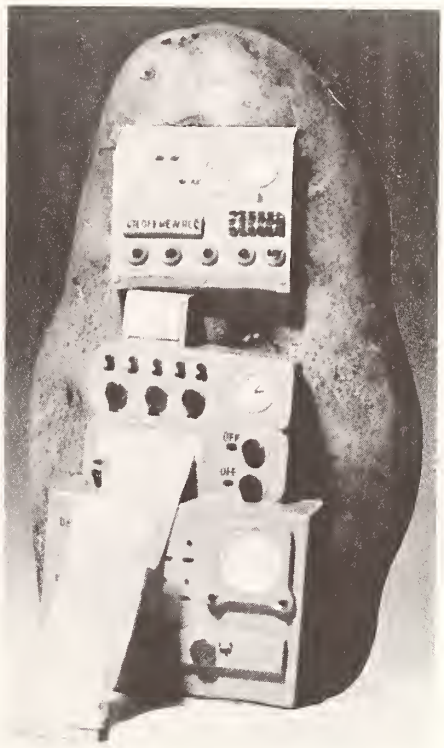
Governor Straub, the Commission on Aging and the Oregon legislature are pleased with the results of Project Independence. Testimony to this is that the legislature appropriated $2.75 million for the program for the two-year period beginning July 1977—nearly three times the appropriation in the previous two-year period. This makes possible expansion of services to many more persons (it is estimated that the project now serves about one-fifth of those eligible) and improvement of the administration of the program. ■

Seeing is believing.

He will never find the answer if he can't see the problem. If your child needs glasses, the Medicaid Program can provide them. Just as we provide immunizations against polio, whooping cough, and measles . . . treat anemia, TB, and sickle cell disease. To find out if your family is elegible, contact your local Social Service or Welfare Office today. Medicaid. Worth looking into.

For a free supply of these posters, write: Editor, the *Forum*.

Idaho to Save $1.4 Million Annually in Processing Medicaid Bills.



by John Piper

In January, Idaho's method for paying Medicaid bills switched from a mechanical operation to a highly-computerized system, and early indications support estimates that the new system will save about $1.4 million annually. This savings is expected to accrue because the new system will help spot duplicate billings, and billings for unnecessary and unauthorized treatment.

"Comparing our new Medicaid Management Information System to what we formerly had is like comparing the first Stone Age cart with round wheels to a Rolls-Royce," says Jim Wilson, administrator of the state's Division of Welfare, Department of Health and Welfare.

The annual operating cost of the system is about $600,000 or $1.25 for each of the 480,000 claims processed annually. Of this, the Government will pay 75 percent of the operating costs after the system receives Federal certification, compared with 50 percent the Government pays states that do not have such a system.

In addition to saving money, the new system will pay 90 percent of the claims within 30 days. With the old system, it took between 60 and 90 days to pay them.

Under the old system, claims from health providers were examined by employees who tried to spot duplicate billings, errors or fraudulent claims. Although a computer was used, it was nonetheless largely a hand operation. The computer was equipped to screen bills for less than a dozen items, but "didn't catch a whole lot," according to Mr. Wilson.

With the new system, the computer can screen hundreds of items and can virtually eliminate duplicate billing. This reduces "human time" so it can be focused on evaluating claims the computer has rejected and spot checking the reports generated by the computer. "The new system will not result in reduced staff," says Mr. Wilson, "because the operation was severely understaffed in the past. The division's claims have been processed by 13 persons, compared to another state which employees 80 persons to handle about the same number of claims."

To avoid front-end development cost, the state elected to contract for development of the system rather than engineering its own.

Computer terminals, located in the division's Boisie office, transmit data via telephone lines to the contractor's computer in San Francisco. Retrieved information is displayed on the terminals' visual display units.

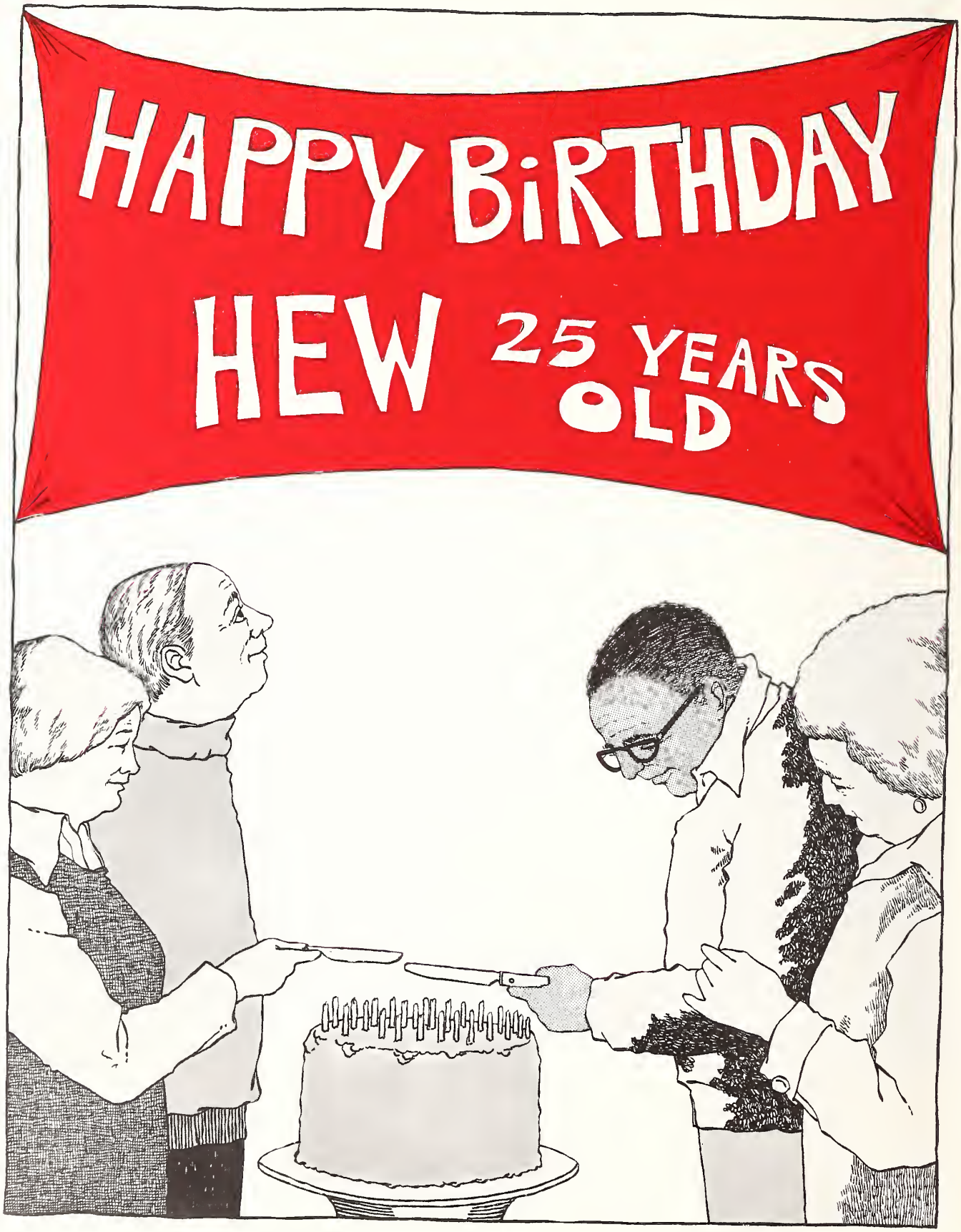
Although cost control is the primary goal of the system, there are many side benefits. Where the old system was basically a mechanism to spot check for duplicate billings, the new system will provide management with a wealth of information. For example, the computer can be programmed to provide information about such things as trends in expenditures, which can come in handy at budget time.

It can also check whether the treatment given was the generally accepted treatment for a diagnosis, and whether the service performed is within the medical policy guidelines approved by the state legislature.

The system can also be used to improve the quality of health care. For example, if it finds that a certain physician is prescribing far more doses of a drug than the average, the physician may be overusing the drug and can be persuaded to cut down.

From the time the system was conceived four years ago until it became operational on the first business day of this year, many barriers had to be hurdled and many problems had to be solved. "What kept the staff going during this ordeal," according to Mr. Wilson, "was the knowledge that we would be able to do a better job, while saving two to three times the operating costs each year." ■

John Piper writes for Serving, *the newspaper of Idaho's Department of Health and Welfare. This article is a condensation of an article which appeared in* Serving.


HAPPY BIRTHDAY
HEW 25 YEARS OLD

Medicare Counts Successes on HEW's 25th Anniversary.

by Bill S. Byrd

Any birthday, and particularly one that marks a quarter century, is a time for looking back and looking ahead. Certainly, Medicare must be counted as one of the department's most successful programs. This review traces the situation of the elderly before Medicare, measures the achievements of the program, assesses its shortcomings and suggests some directions for its future.

In retrospect, the past is often endowed with a virtue and simplicity it never possessed. I doubt, however, whether any of the nation's elderly have any nostalgia for their health care situation prior to 1966 when the Medicare Program became operational. The majority of the elderly, quite simply, were without any comprehensive health insurance protection. While private insurance was making a substantial effort in this direction, the problem was clearly too immense for its resources.

Except for hospital insurance—and even that was inadequate by today's standards—the elderly were essentially dependent upon their meager savings, the generosity of their children, the charity of hospitals and physicians, and in more cases than it is pleasant to remember, upon the charity of society under state and local programs in which the elderly sacrificed a measure of dignity in return for a measure of help.

There is no way in which an objective observer can discount the profound change for the better which has occurred under Medicare. The fact that Medicare, in its first 11 years of operation, has paid out over 100 billion dollars for health care services simply has to be entered into the equation in assessing what this program has meant to the elderly and to the severely disabled, to whom Medicare was extended a little over four years ago.

But there is another aspect of health care which Medicare has brought within the reach of the elderly and the disabled which is not disclosed by dollar amounts. This is the types of health care to which those under Medicare now have access. While Medicare is by no means an all-inclusive health insurance program, it is nonetheless very comprehensive. Prior to Medicare, it was a very fortunate American, of any age, whose health insurance protection covered much more than inpatient hospital care, surgical care, physician services in connection with a hospital stay and outpatient hospital services on an emergency basis.

Coverage for home and office visits by a physician, outpatient clinic services, post-hospital services in a skilled nursing facility, home health agency services, the rental or purchase of durable medical equipment, and independent laboratory services were ingredients only of the better private health insurance plans available to a very few Americans through group health where they worked. In this respect, Medicare's inclusion of this wider range of benefits not merely provided the members of the Medicare program with a more comprehensive set of benefits than they had previously enjoyed—but it also established a minimum set of benefits which are increasingly becoming standard among private health insurance offerings for the American public as a whole.

There is another element of access which should be mentioned—timeliness. The two factors just mentioned—the reduction of financial barriers to the use of health services and the variety of benefits offered—do not merely affect the over-all use of health care services. They, most importantly, encourage early attention to health problems.

The risks of deferred medical care are great in any age group. Particularly among the elderly, however, early diagnosis based on preliminary symptoms can be of critical importance in preventing irreversible damage.

There is another major area in health care delivery to which Medicare has made significant—and little noted—contribution: the quality of services for Medicare beneficiaries. In order to participate in or be reimbursed by Medicare, hospitals, skilled nursing facilities, home health agencies, independent laboratories, outpatient physical and speech therapy providers, and ambulance services must meet health and safety standards which, in many respects, exceed what was required by state and municipal licensing authorities.

Under the impetus of Medicare standards, thousands of health care providers have added services, overcome health hazards, particularly in the area of fire safety, achieved a significantly higher proportion of accredited members among their paraprofessionals and technical staffs. And through the financial support afforded by the program, were able to promptly implement the high standards made mandatory by the program.

But Medicare is not a saga of total success. There are a number of prob-

Bill S. Byrd, director of Medicare's Professional Relations Staff, has been an executive with the Medicare Program since its inception.

lem areas which are not unique to Medicare, but common to all health insurers.

The first of these problems, of course, is rapidly escalating costs. One can hardly open a newspaper these days without reading about petitions from private health insurers for increased premium rates. It has become an almost annual or even a semi-annual event.

In Medicare's first full year of operation—in fiscal year 1967—benefits totaled $3.2 billion. In fiscal 1977, which ended September 30th last year, Medicare benefit payments amounted to $21 billion—nearly a seven-fold increase. It is true that part of the increased costs over the last four years are attributable to the inclusion of nearly three million disabled beneficiaries in 1973. But even with adjustments for that, the costs of the program have multiplied exorbitantly compared to the first year.

There is a wealth of economic theory and a considerable degree of dispute over the mix of factors which have produced these staggering increases. The extremes of view range from the assertion that the health community is reaping windfall profits from the increasing use of third-part mechanisms to pay for health care services, to the position that it is third-party mechanisms themselves, whether public or private, which force higher health care prices because of chronic underpayment. Almost certainly the truth lies somewhere between.

But regardless of the reasons, what is happening is a virtual repetition of the conditions which existed just before Medicare was enacted. Once again the elderly, the disabled, and the otherwise medically indigent are becoming unable to secure adequate health care without out-of-pocket payments—and these payments are growing more and more unbearable in relation to their relatively fixed incomes. What is even more significant, with respect to the forces which underlie social change, is that the great body of America's middle class is becoming increasingly vocal about its burden of health care costs.

The second problem is the matter of how health care services are used—most particularly, the predominance of inpatient hospital services. Medicare pays a little over 70 percent of its total benefits for that one service. When you add to that the cost of the hospital visits by physicians and the costs of other medical services associated with a hospital stay, the Medicare payments for inpatient hospital care and medical care approximate 80 percent. In the current fiscal year, the dollar amount involved will be close to $20 billion.

The unavoidable question is whether we may not have traditionalized inpatient hospital care at an extremely high cost while neglecting to use alternative levels of care which are less expensive, frequently more medically appropriate and often more convenient to the patient. It is well documented that when a health insurance program covered inpatient hospital care but did not cover alternative care, there was a powerful incentive to place an insured patient in the hospital.

With the advent of Medicare and the increasing tendency of private insurance to enlarge coverages to include alternatives to hospital care, this incentive has been measurably reduced. As a matter of fact the average length of hospital stay by Medicare beneficiaries has been reduced by more than three days since the beginning of the program—and recent studies of non-Medicare patients have also shown a progressive decline of hospital stay.

There are substantial savings in this trend without loss of quality in patient care. It is a trend which Medicare—and all other health insurers—must reinforce. We have too substantial an array of hospital alternatives now available to us to accept—and pay for—hospital admissions when outpatient diagnostic services would be appropriate. In addition we must not accept—and pay for—extended hospital stays when skilled nursing facility care or care from a home health agency would be entirely appropriate for convalescent care. Moreover, with the growth of the ambulatory surgical centers and the promising concept where the patient receives institutional services during the day and spends his nights at home, we have additional avenues of recourse.

The central figure in achieving a better use of non-hospital resources is the prescribing physician. It is the physician who chooses the location of care, the type of care to be furnished and the duration of that care. The physician, in short, directs the flow of the great bulk of goods and services delivered by the health care industry.

Last year most of the more than $140 billion spent for personal health care services was the result of the choices made by physicians. The power to control expenditures of this magnitude imposes a corresponding responsibility not to sacrifice quality of care in the interests of economy but, certainly, to take economy into account in delivering quality care.

One of the legacies of Medicare is that this program established—once and for all—that the Government and the health community can work together very effectively. It is still asserted, from time to time, that Government and medicine cannot mix without detriment to medicine. After 11 years of Medicare, I do not see how that can be said with any conviction.

As in any partnership in so complex an enterprise there can be differences of opinion, but it is a mischievous thing to exaggerate them out of proportion and to portray dialogue as if it were dissension—or to create the image of confrontation, when what is occurring is consultation. In the area of health, public policy and professional practice are now partners—and very able partners, in my view, as demonstrated under Medicare. The achievement of our common goal—to keep improving the American health care system and to assure the unimpaired access of the American public to that system—is only possible if we build that partnership into the truly effective instrumentality it can potentially become. There is simply no alternative to strengthening this partnership—neither Government alone nor the health field by itself can do what needs to be done. Together—in a relationship of mutual respect—I see no possibility of failure. ■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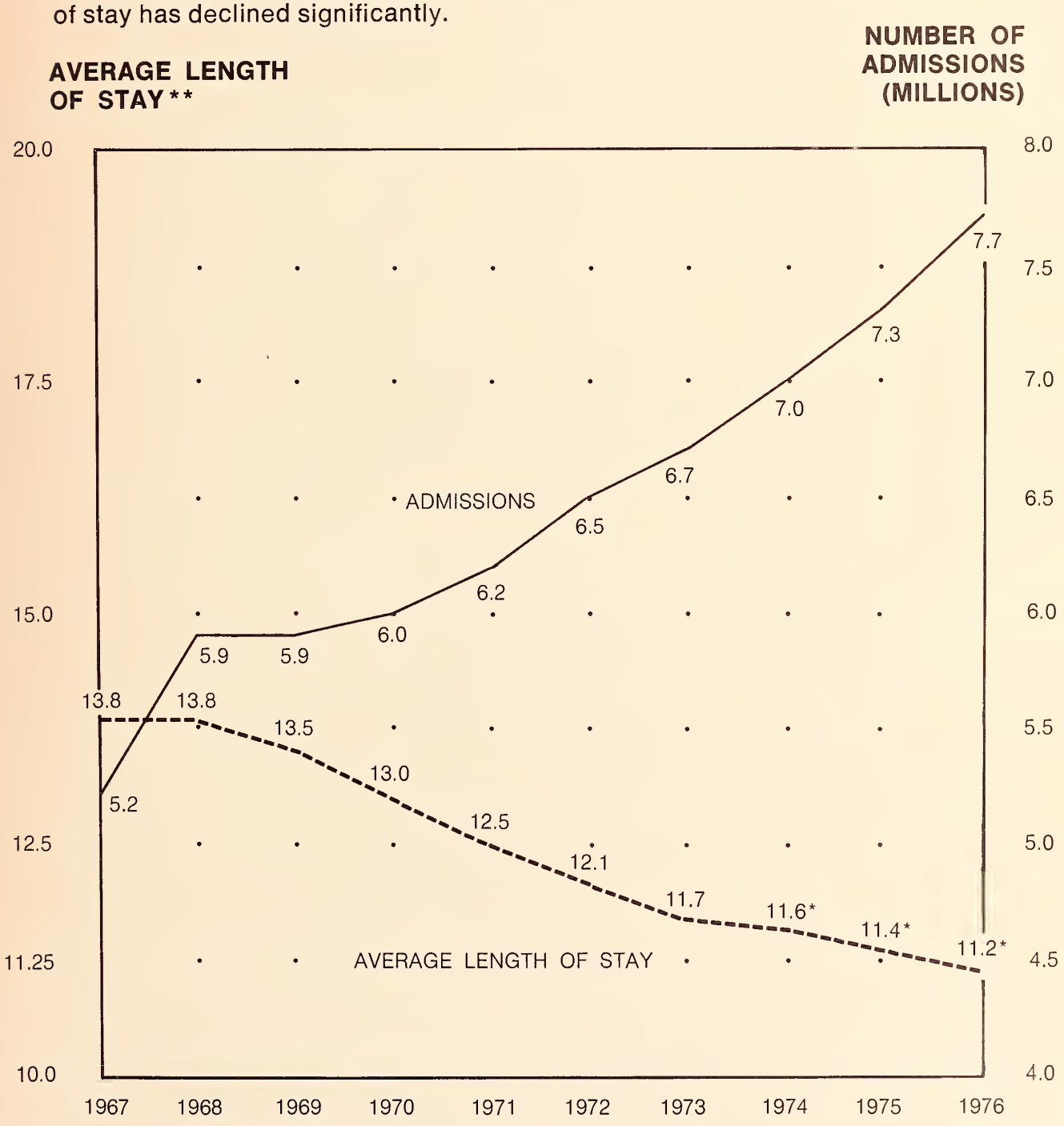

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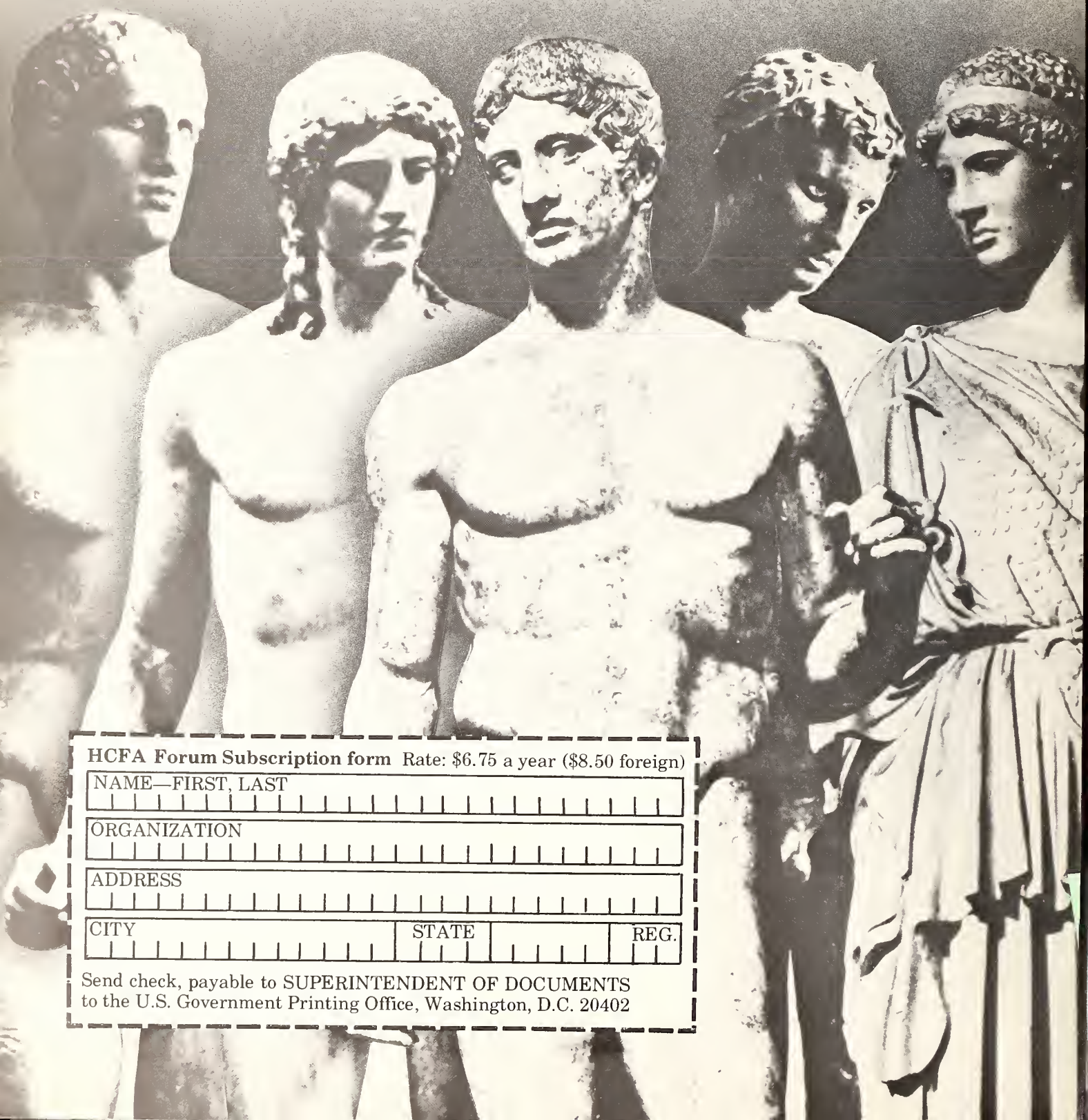

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